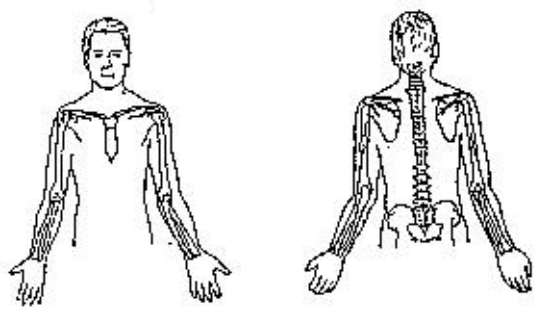
Patient Name _____

PATIENT SELF EVALUATION
SHOULDER

Please answer the following questions regarding your shoulder condition.

1. Are you having pain in your shoulder now? YES NO

2. Please mark your pain on the following diagram



3. Do you have pain in your shoulder at night? YES NO

4. Are you taking any pain medication? YES NO

5. Are you taking narcotic pain medication such as codeine? YES NO

6. On an average, how many pills do you take per day?

1 2 3 4 5 6 7 8 9 10+

7. How bad is your pain today? (Mark scale below)

1 2 3 4 5 6 7 8 9 10+

No pain Some pain Excessive pain

8. Does your shoulder feel unstable? (As if it is going to dislocate) YES NO

9. How unstable is your shoulder? (Mark the scale below)

1 2 3 4 5 6 7 8 9 10+

Very Unstable Very Stable

10. Circle the number corresponding below that indicates your ability to do the following activities:

Key: 0 = Unable to do
1 = Very difficult to do
2 = Somewhat difficult to do
3 = Not difficult at all

ACTIVITY	***RIGHT ARM***	***LEFT ARM***
Put on a coat	0 1 2 3	0 1 2 3
Sleep on your side	0 1 2 3	0 1 2 3
Wash your back/Hook your bra	0 1 2 3	0 1 2 3
Manage toiletries	0 1 2 3	0 1 2 3
Comb your hair	0 1 2 3	0 1 2 3
Reach a high shelf	0 1 2 3	0 1 2 3
Lift 10lbs above your shoulder	0 1 2 3	0 1 2 3
Throw a ball overhand	0 1 2 3	0 1 2 3
Do usual activities	0 1 2 3	0 1 2 3
Do usual sport	0 1 2 3	0 1 2 3