SHOULDER QUESTIONNAIRE

Patient Name: _____
Last name, First name

Circle painful side - Right shoulder or Left shoulder

1) How long have you had shoulder pain? Days____ Weeks____ Months ____Years____

2) Is this the first episode of shoulder pain? Yes____ No _____

3) History of injury to the shoulder? Yes___ No____ If yes, explain briefly_____
_____

4) When does your shoulder hurt? At night? Yes___ No___ With overhead activity? Yes___ No___

Is your shoulder painful when you place it across your chest? Yes _____ No _____
Reaching over your head? Yes___ No ___
Reaching behind your back? Yes_____ No _____

5) Neck pain? Yes_____No _____ Do you have numbness or pins or needles? Yes____ No____

6) Have you received any previous treatment for this condition? Yes____ No ____
If yes, what type of treatment?_____

7) Have you had any X-rays? Yes ___ No____ MRI's Yes _____ No_____