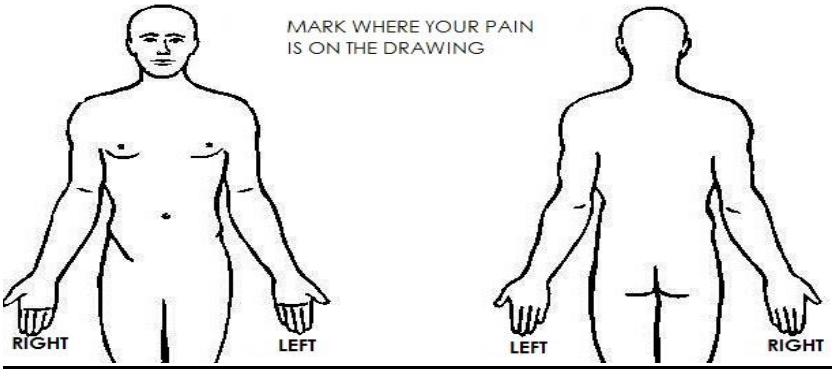
SHOULDER EVALUATION: Todays date:_____

Name:_____ Age:_____ Sex:_____ Chart:_____



How long have you had shoulder pain?_____

Which hand do you throw with? (circle one) Left Right

What started the pain?_____

Do you have pain in your shoulder at night? (circle one) Left Right

Do you take pain medication? Yes No

How many pills do you take each day? (average) _____

Please list pain medications you are taking:_____

Does your shoulder feel unstable (as if it is going to dislocate)? Yes No

How bad is your pain today? (circle a number corresponding to your pain level)

No Pain 1 2 3 4 5 6 7 8 9 10 **Extreme Pain**

How unstable is your shoulder? (circle the corresponding number)

Very Stable 1 2 3 4 5 6 7 8 9 10 **Very Unstable**

Circle the number that indicates your ability to do the following activities:

0 = unable to do; 1= very difficult to do; 2 = somewhat difficult; 3= normal

	RIGHT ARM	**LEFT ARM**
Put on a coat or shirt	0 1 2 3	0 1 2 3
Wash your back	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
Carry 10lbs at your side	0 1 2 3	0 1 2 3
Wash your opposite armpit	0 1 2 3	0 1 2 3
Throw a ball overhand	0 1 2 3	0 1 2 3
Do usual work- LIST_____	0 1 2 3	0 1 2 3