

Shoulder Evaluation

Please be as complete as possible and print clearly

Name: _____ Today's Date ___/___/___ Age: _____ Height: _____ Weight: _____

Occupation: _____ Family Physician: _____

Who referred you to this office? _____

Hand Dominance: Right Left

Involved Shoulder: Right Left

HISTORY OF INJURY

Did you have an injury to your shoulder? Yes No

When did the injury occur or when did *the symptoms* begin (month, day, year)? _____

How did the injury occur? _____

Do you have: Pain Loss of motion Weakness Radiating pain down the arm

Numbness or tingling

Location of your shoulder pain: Side Front Back Top Neck Shoulder blade

Is the pain: Sharp Dull Aching Burning Constant Activity related

Does the pain wake you up at night? Yes No

Is the pain present: During activities After activities

What aggravates the symptoms?

Reaching behind back

Reaching overhead

Throwing

Pushing

Lifting

Other: _____

Have you had prior problems or surgery on this shoulder? Yes No

What makes the symptoms better? _____

Have you ever dislocated your shoulder? Yes No

Does it slip out of joint or feel unstable? Yes No

Have you had any treatment related to this injury? Yes No

If yes, please check off which treatments and any improvement:

Medications: Greatly helped Moderate help No help

Physical Therapy: Greatly helped Moderate help No help

Injections: Greatly helped Moderate help No help

Other: _____

With regards to this injury, have you had: X-Rays MRI Other

PAST MEDICAL HISTORY

Please list any conditions you are being treated for: _____

Please list any medications you are currently taking: _____

Please list any surgical procedures: _____

Medication Allergies: _____ or No Known Drug Allergies

SOCIAL AND FAMILY HISTORY

Do you smoke: Yes No If yes, how many packs per day: ½ 1 2 More

Are you married? Yes No

Please list any conditions or diseases that run in the family: _____

REVIEW OF SYSTEMS

Please check off if you have any of the problems listed below:

Migraines	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Bleeding disorders	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Heart disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Phlebitis/blood clots	<input type="checkbox"/> Yes	<input type="checkbox"/> No
High blood pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Kidney disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Psoriasis or gout	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Ulcer/stomach probs	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hepatitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No

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Exam Findings

Equal AER	Yes No	Speed's +	Yes No	Scap border	Yes No
Painful arc	Yes No	Neers +	Yes No	Coracoid pain	Yes No
Infra	___ of 5 5/5	Hawkins +	Yes No	Infera	Yes No
Subscap	___ of 5 5/5	AC joint pain	Yes No	Abduction	Yes No
Supra	___ of 5 5/5	Passive ER nl	Yes No	Antetilt	Yes No
Jobes +	Yes No	Passive IR nl	Yes No	Scap squeeze	Yes No
Empty can +	Yes No	Passive FF nl	Yes No	Scap relocate	Yes No
Cross Add +	Yes No				
O'Briens +	Yes No				

Physician signature: _____ Date: _____