HealthZone MD
FAMILY AND SPORTS MEDICINE WELLNESS CENTER

Shoulder Form

Name: _____

Date: M M / D D / Y Y Y Y

IDENTIFYING THE PAIN

Describe the injury/problem and past shoulder history

Date of original injury
M M / D D / Y Y Y Y

Which Shoulder
❑ Right ❑ Left

Dominant Hand
❑ Right ❑ Left

Have you felt:

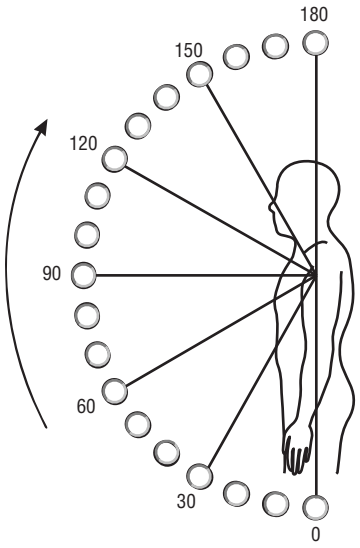
Shift or Pop	❑ Yes	❑ No	Tingling/Numbness	❑ Yes	❑ No	Grinding	❑ Yes	❑ No
Dislocation	❑ Yes	❑ No	Bruising	❑ Yes	❑ No	Pain During Activity	❑ Yes	❑ No
Limited Motion	❑ Yes	❑ No	Pain While Sleeping	❑ Yes	❑ No			

Has this injury hindered your ability to resume desired activities? ❑ No ❑ Yes

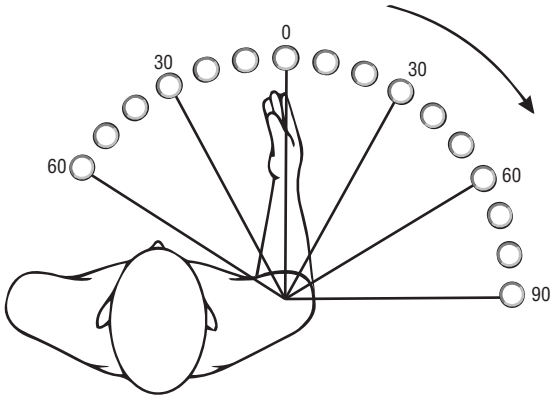
Describe: _____

IDENTIFYING THE PAIN

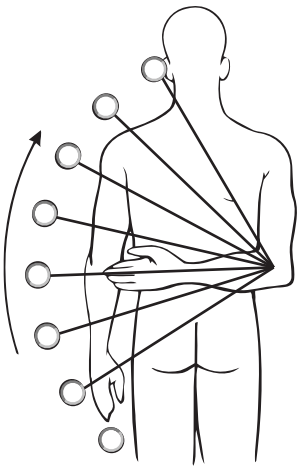
How high can you raise your arm without assistance?



With your elbow at your side, how far outward will your forearm go?



How far inward and upward behind your back can you reach?



ALLEVIATING FACTORS

- ❑ Nothing Helps
- ❑ Rest
- ❑ Exercise
- ❑ PT/OT
- ❑ Orthotics
- ❑ Previous Surgery
- ❑ Limited Weightbearing
- ❑ Narcotics
- ❑ Over-the-counter Medication
- ❑ Viscosupplementation Injection
- ❑ Ice
- ❑ Elevation
- ❑ Stretching
- ❑ NSAIDs
- ❑ Brace
- ❑ Sling
- ❑ Chiropractic Care
- ❑ Epidural Steroid Injection
- ❑ Cortisone Injection
- ❑ Other: _____

AGGREVATING FACTORS

- ❑ Cannot Identify
- ❑ Carrying
- ❑ Pushing/Pulling
- ❑ Grasping
- ❑ Throwing
- ❑ Weightbearing
- ❑ Previous Surgery
- ❑ Changing Clothes
- ❑ Daytime
- ❑ Cold Weather
- ❑ Driving
- ❑ Lifting
- ❑ Twisting
- ❑ Gripping
- ❑ Squeezing
- ❑ Range of Motion
- ❑ Exercise
- ❑ Computer Use
- ❑ Morning
- ❑ Nighttime
- ❑ Damp Weather
- ❑ Other: _____

Reset
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