CHICO ORTHOPAEDIC SURGERY & SPORTS MEDICINE
SHOULDER QUESTIONNAIRE

PATIENT_____ DATE_____

Right Left Both

Do you feel your injury is work-related? Yes No
Is there an open work comp claim for this injury? Yes No
Is your claim in Litigation? Yes No

Was there any injury, which you remember that caused the pain? If yes, can you recall the date of injury? _____
Does the pain radiate anywhere (e.g., up neck or down arm)?

PAIN
Where does it hurt?
How long has it been painful?
On a scale of 1 to 10 (10 being the worst pain), how would you rate your pain?_____
Frequency of pain: Constant Intermittent
Character of pain: Sharp Dull Nagging
Aggravating Activities (please circle):
Reaching forward/overhead throwing lifting over shoulder work
Increased at night Pain wakes you up at night
Where exactly is most of your pain? _____
Do you have shoulder pain with head/neck movements? Yes No

Do you have history of neck/back problems? Yes No

Numbness in your upper extremity Yes No

Giving out/dislocation/When Yes No

Locking, catching, clicking Yes No

Swelling Yes No

Loss of motion Yes No

Prior shoulder problems Yes No

Prior shoulder surgery Yes No

Presently working Yes No N/A

Treatment received:
Medications _____
Injections _____
Physical therapy (how many sessions) _____
Other Physicians/Chiropractic _____
Other _____