Orthopedic Specialty Associates
New Patient Questionnaire - Shoulder

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Name: _____ DOB (age): ___ / ___ / _____ (___) Date: ___ / ___ / _____

Primary Care Physician (PCP): _____ Occupation: _____

Referred by (circle one): Physician Family/friend Athletic Trainer Coach Internet Other: _____

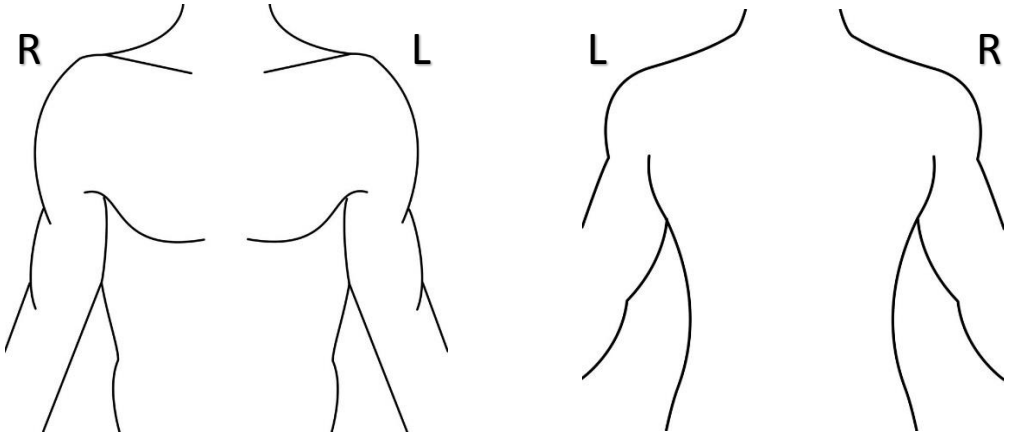
Hand dominance: Right Left

Injured shoulder: Right Left Both

Nature of Symptoms

Location: use arrows or shade all areas of pain

Worst pain: place an "x" where **most** of your pain is or where your pain **originates**



Date that symptoms began: ____ / ____ / _____

Was there a specific injury that occurred? Yes No Unsure

If yes, briefly explain: _____

Are your symptoms getting: Better Worse Staying the same Unsure

Have you previously injured or had surgery on the involved extremity? Yes No Unsure

If yes, briefly explain: _____

Have you had previous treatment to the involved extremity related to a previous injury? Yes No Unsure

If yes, briefly explain: _____

Is your pain: Constant Intermittent Associated with activity Easily reproducible

Is your pain: Sharp Stabbing Achy Throbbing Tingling Numbing Electrical Other: _____

Does your pain radiate? Yes No

If yes, where? Side of upper arm Front of arm Past the elbow Into fingers Base of neck Upper back

Please list specific activities or positions that aggravate your pain: _____

_____

Does it hurt to: Lift (front / side / overhead) Reach (front / side / behind / overhead / across your body)
Put on/remove clothes

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Is your pain aggravated by sports or recreational activity: Yes No

If yes, describe aggravating activities: _____

Do you have pain at night? Yes No **If yes, does it keep you up at night/wake you up at night?** Yes No

If yes, when? Laying on the involved side Laying on uninvolved side Any position

Since the onset of pain, have you experienced: Weakness Loss of motion Popping Clicking Instability

Do you have numbness/tingling in your hand? Yes No

If yes, explain how often: _____

Do you have history of neck: Stiffness Pain Herniated disc Surgery Injections

If you are under the care of a physician for your neck, who? _____

Has your shoulder ever dislocated? Yes No Unsure

If yes, when? How many times? _____

Previous Treatment for Current Injury

Rest: Yes No

Injections: Yes No Unsure

If yes: How many? _____ Most recent: _____ Did it help? _____

Physical Therapy: Yes No Unsure

If yes, how long? _____ Therapist name & location: _____

Other treatment: _____

Previous Imaging on Involved Extremity

X-rays: Yes No If yes, when? _____ Where? _____

MRI: Yes No If yes, when? _____ Where? _____

CT Scan: Yes No If yes, when? _____ Where? _____