Name:
Chart:
Date:

SHOULDER HISTORY **NAME** ______________________ **DATE** ____________

Please answer the following questions that pertain to your injury or problem with your shoulder by checking, circling or writing the answer. Thank you.

Is this exam for your right shoulder _______, left shoulder _____ or both shoulders_________?

Please give the date you began having trouble with your shoulder or the date you injured your shoulder__________

Where did your injury occur? ______________________________

Are you right or left handed? ______________________

Is this injury due to the any of the following?

____ Auto accident
____ Falling
____ Motorcycle
____ Football
____ Wrestling
____ None of the above, please state here ______________________

____ Snowmobile accident
____ Baseball accident
____ Basketball accident
____ Skiing accident

BRIEF HISTORY: ______________________________

____

If you are having pain, please check one of the following:

____Severe pain (prevents normal daily activity)
____Throbbing pain
____Moderate pain
____Aching pain

PLEASE CIRCLE EACH ANSWER. THANK YOU.

Do you have pain at night? YES NO
Do you have neck pain? YES NO
Is the neck pain necessarily related to your shoulder pain? YES NO
Does your pain go down into your right arm? YES NO
Does your pain go down into your left arm? YES NO
Have you had any swelling in your fingers? YES NO
Have you had any other joint pain or swelling? YES NO
Does it hurt you to move your shoulder forward? YES NO
Does it hurt you to move your shoulder upward? YES NO
Do you have a grinding sensation in your shoulder? YES NO
Do you have a clicking sensation in your shoulder? YES NO
Do you have stiffness in your shoulder in the morning? YES NO
When you use your arm, does your shoulder hurt in the morning? YES NO
When you use your arm, does your shoulder get worse? YES NO
Is your shoulder swollen? YES NO

Have you had previous problems or injury to your shoulder? YES NO
If yes, please state when and what kind of treatment you received.

____

Have you had any treatment for your present shoulder problem?
YES NO If yes, please state when and what kind of treatment.

____

Are you on any medications at the present time for this problem?
YES NO If yes, please state here ______________________

If you have seen another physician for this problem, please give name and address ____________

____

If you have been off work because of this problem or injury, please give the date you last worked. ______

____

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