**Bay Area Surgical Specialists**

**Benjamin Busfield M.D., F.A.A.O.S.**

**Orthopedic Surgery and Sports Medicine**

**SHOULDER COMPLAINT:**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Profession: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Hand Dominance**: 🞏RHD 🞏LHD 🞏Ambidextrous

**Which shoulder hurts**: 🞏Left 🞏Right 🞏Both

**How long has the shoulder hurt?** \_\_\_\_\_ Months or \_\_\_\_\_ Years

**Any past shoulder injuries?** 🞏Yes 🞏No **Any past dislocations?** 🞏Yes 🞏No

**Any past shoulder surgeries**? 🞏Yes 🞏No If yes, what year and what surgery was done? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Pain (rate from 0-10, 10 is worst, 0 is no pain**) \_\_\_\_\_

**Describe pain**: 🞏Burning/tingling 🞏Deep ache 🞏Stabbing 🞏Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Pain location:** 🞏 Front of shoulder 🞏 Back of shoulder 🞏 Side of shoulder 🞏 Side of arm 🞏 Neck

**Associated symptoms**: 🞏 Tingling in hand 🞏 Neck pain 🞏 Clicking 🞏 Stiffness

**Any recent treatment**? Anti-inflammatory meds 🞏Yes 🞏No Physical Therapy 🞏Yes 🞏No

Chiropractor 🞏Yes 🞏No Ice 🞏Yes 🞏No Injections 🞏Yes 🞏No

**What makes pain better?** Rest from activity 🞏Yes 🞏No Pain medications 🞏Yes 🞏No

 Physical Therapy 🞏Yes 🞏No Ice 🞏Yes 🞏No

**What makes pain worse?** Reaching overhead 🞏Yes 🞏No

 Reaching behind back 🞏Yes 🞏No

Lifting 🞏Yes 🞏No

Lifting/pushing 🞏Yes 🞏No

Sleeping 🞏Yes 🞏No

Combing hair 🞏Yes 🞏No

Work 🞏Yes 🞏No