Bay Area Surgical Specialists
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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

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