Shoulder Evaluation

Please be as complete as possible and print clearly

Name:____ Today's Date___/___/___ Age:_____ Height:________ Weight:__________

Occupation:____ Family Physician:____

Who referred you to this office?____

Hand Dominance: Right Left Involved Shoulder: Right Left

HISTORY OF INJURY

Did you have an injury to your shoulder? Yes No

When did the injury occur or when did *the symptoms* begin (month, day, year)?____

How did the injury occur?____

____

Do you have: Pain Loss of motion Weakness Radiating pain down the arm

Numbness or tingling

Location of your shoulder pain: Side Front Back Top Neck Shoulder blade

Is the pain: Sharp Dull Aching Burning Constant Activity related

Does the pain wake you up at night? Yes No

Is the pain present: During activities After activities

What aggravates the symptoms?

Reaching behind back	Reaching overhead	Throwing
Pushing	Lifting	Other:________________

Have you had prior problems or surgery on this shoulder? Yes No

What makes the symptoms better?____

Have you ever dislocated your shoulder? Yes No

Does it slip out of joint or feel unstable? Yes No

Have you had any treatment related to this injury? Yes No

If yes, please check off which treatments and any improvement:

Medications: Greatly helped Moderate help No help

Physical Therapy: Greatly helped Moderate help No help

Injections: Greatly helped Moderate help No help

Other:____

With regards to this injury, have you had: X-Rays MRI Other

PAST MEDICAL HISTORY

Patient Name: ____ Date of Birth:_______________________

Height: _______ Weight: ________

Please list any conditions you are being treated for:____

____

Please list any medications you are currently taking____

____

Please list any surgical procedures:____

____

Medication Allergies:____ or No Known Drug Allergies

SOCIAL AND FAMILY HISTORY

Do you smoke: Yes No If yes, how many packs per day: ½ 1 2 More

Are you married? Yes No

Please list any conditions or diseases that run in the family:____

____

Review of Symptoms

Please check all that apply

General:	**Cardiovascular:**	**Musculoskeletal:**	**Neurological:**
☐ Feeling Well	☐ Chest Pain	☐ Calf Pain	☐ Dizziness
☐ Fever	☐ Palpitations	☐ Joint Swelling	☐ Unsteadiness
☐ Chills	☐ Edema	☐ Joint Pain	☐ Weakness
☐ Fatigue	☐ Phlebitis	☐ Joint Stiffness	☐ Numbness
		☐ Muscle Weakness	☐ Unusual Sensation
Skin:	**Gastrointestinal:**	☐ Muscle Pain	☐ Fainting
☐ Bruising	☐ Heartburn/Reflux	☐ Muscle Atrophy	☐ Headaches
☐ Rash	☐ Constipation	☐ Leg Cramps	
Respiratory:	**Psychiatric:**	**Hematology:**	**Geniourinary:**
☐ Cough	☐ Anxiety	☐ Anemia	☐ Recurrent Urinary Infection
☐ Wheezing	☐ Depression	☐ Blood Clots	☐ Prostate Enlargement
☐ Difficulty Breathing	☐ Insomnia	☐ Nose Bleeds	☐ Prostate Cancer
	☐ Dementia		

Signature:____ **Date**______/______/______

Physician Signature:____ **Date**______/______/______