SHOULDER INJURY - INTAKE FORM

Name: _____ **Age:** _____ **DOB:** _____ **Today's Date:** _____

Primary care physician: _____ **Referred by:** _____

Occupation: **Sports/Activities:**

Are you (please circle): RIGHT-HANDED LEFT-HANDED

Which shoulder are you here for today? RIGHT LEFT BOTH

When did your symptoms begin (specific date or in weeks/months/years**)?** _____

Was there a specific injury? Yes / No (If yes please describe): _____

_____

P**rior surgery/injury to this shoulder?** Yes / No (Describe) _____

NATURE OF SYMPTOMS

Is your pain getting: BETTER WORSE SAME

Please rate your *average* level of shoulder pain: (none) 1 2 3 4 5 6 7 8 9 10 (worst)

Where is most of your pain? FRONT BACK OUTER SIDE (Lateral) TOP CANT TELL

Is your pain (or other symptoms): CONSTANT INTERMITTENT ASSOCIATED WITH ACTIVITY

Please list activities that are painful/difficult to perform: _____

_____

Is your pain: SHARP STABBING DULL ACHING

Do you have: a) Pain at night: Yes / No b) Pain with overhead activity: Yes / No

Please circle any of the following that you notice:

LOSS OF MOTION WEAKNESS POPPING /CLICKING INSTABILITY

Do you have neck pain? Yes / No **Numbness or tingling into your hand or arm?** Yes / No

Has your shoulder ever dislocated? Yes / No (If yes, how many times _____)

PAST TREATMENT

Medications: _____ **Do they help?** Yes / No

Injections: Yes / No **How many?** _____ **Most recent** _____ **Did it help?** Yes / No

Physical Therapy: Yes / No **How long?** _____ **Did it help?** Yes / No

Other treatment: _____

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