ORTHOPEDIC SHOULDER QUESTIONNAIRE

PATIENT NAME:	TODAYS DATE:			
CHIEF COMPLAINT:				(Seeing provider today for
AFFECTED SIDE: Right	Left Both	shoulders		
REFERRED BY:				
(Physician)		(City, State)		
ONSET OF CONDITION: Abrupt Gradual		PRIOR SHOULDER PROBLEMS? No Yes CURRENTLY ABLE TO WORK? No Yes		
TREATMENT: (Mal	HELPED kes pain better)	NO EFFECT OR WORSENED (Makes pain worse)		NOT HAD (Not tried or needed)
Heat or Ice	¥ 		<u> </u>	
Physical Therapy	<u> </u>			
Tylenol or over the counter pain med				
Anti-inflammatory medication (Advil, Aleve, Ibuprofen)	a			
Narcotic Medication	V			
Stretching or Strengthening				-
Glucosamine/Chondroitin				
Cortisone or Steriod shots	7			
Surgery				
PAIN Is your pain Constant?	No	Yes	Sharp	No Yes
During the day	No No	Yes	Shooting	No Yes
During the night	No	Yes	Tingling	No Yes
Worse with the activity/use	No	Yes	Dull	No Yes
Awakens from sleep	No	Yes	Aching	No Yes
	W. 12 (2000 0)		Numbing	NoYes
CURRENT SYMPTOMS:				ere you have the most pain. where you have lesser pain.
Do you have any stiffness? (difficulty washing your back?)	No	Yes	Front	Back
Do you have weakness?	No	Yes		
Does shoulder feel unstable?	No	Yes	, , ,)	
Any clicking, popping or cracking noises in the shoulder?	No	Yes	1-'	
Do you have neck pain?	No	Yes	Λ Λ Ι	. 1 // /
Any pain below elbow?	No	Yes ')) (((1)
Is your pain aching or numbing?	No	Yes		
Signature of Patient or Legally Responsible Part	у			Date (month/day/year)

Relationship to patient, if not signed by patient

PATIENT NAME & ID#

VIRGINIA MASON MEDICAL CENTER - Seattle WA

Orthopedic Shoulder Questionnaire

