

SHOULDER HISTORY

Name _____ Date ____/____/____

Highest year of school completed _____ Age _____ Male Female Ht. _____ Wt. _____

Currently Working? Yes No Retired If yes, type of work _____

PRESENT COMPLAINT: (check one) **RIGHT SHOULDER** **LEFT SHOULDER**

Please describe the problem: _____

Is present problem related to Injury? Yes No If yes, when _____

Where? Athletics At Work Home School Vehicle Other: _____

Do you have pain: Yes No If yes, grade your pain: 1 2 3 4 5 (1= minor 5 = Severe)

Describe your pain: _____

Locate your pain: **RIGHT SHOULDER** Front Back Armpit Upper arm Neck Radiating
 LEFT SHOULDER Front Back Armpit Upper arm Neck Radiating

Is your pain *increased* by: Lifting Reaching Pulling Pushing Other _____

Is your pain *decreased* by: Position changes Exercise Medications Phys. Therapy Other _____

Have you had any of the following?

	RIGHT SHOULDER		LEFT SHOULDER	
Dislocating	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Swelling	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Locking	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Clicking / Popping	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Grating / Grinding	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Night Pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Are you able to: Walk Yes No Full time Part time
 Play Sports Yes No
 Reach Yes No
 Dress Yes No

Have you been previously treated? Yes No

If yes, when _____ Where _____

Do you have: Rest Ice/Heat Sling Injections Therapy X-Rays Surgery Other: _____

Comments: _____

Have you had previous problems? Yes No **RIGHT SHOULDER** **LEFT SHOULDER**

If yes, when? _____

Describe: _____

From Injury? Yes No If yes, where: Athletics At work Home School Vehicle Other: _____

How was this previous problem treated?	RIGHT SHOULDER		LEFT SHOULDER		DATES
Rest	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Physical therapy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Injections	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Arthroscopy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Open Surgery	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____

Comments: _____

Do you have: Other Joint Problems Urinary Infection Fever Chills Rheumatoid or other Arthritis

Family history of arthritis Other Health Problems: _____

Any additional important information: _____