Name:

DOB:

OrthoCincy

Date:

Shoulder Evaluation

Referring Physician: _____ Primary Care Physician: _____

Name a favorite hobby: _____

Which shoulder is affected?: ☐ Right ☐ Left ☐ Both Does your shoulder feel unstable? ☐ yes ☐ no

Describe how it happened _____

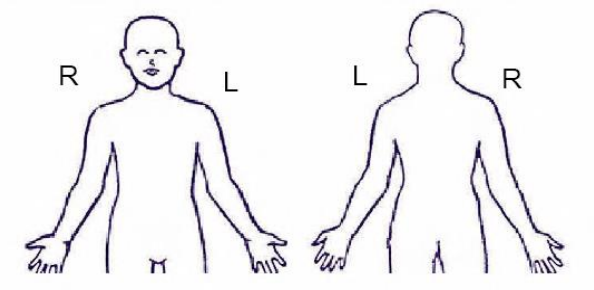
Describe where you were: _____

☐ Personal Injury ☐ Fall ☐ Sports Injury ☐ Work related ☐ Chronic

☐ Auto Accident-were you wearing a seatbelt? ☐ yes ☐ no

The date the symptoms began: _____

On this diagram mark where your pain is:



For each, circle what **BEST** applies:

- The pain is: RARE INTERMITTENT CONSTANT
- The pain is: DULL SHARP ACHY THROBBING BURNING STABBING OTHER: _____

Circle **ALL** that apply:

- Associated symptoms: CATCHING POPPING LOCKING GRINDING SWELLING STIFFNESS INSTABILITY WEAKNESS TINGLING NUMBNESS NIGHT PAIN OTHER _____

When is your pain worse? ☐ Mornings ☐ Evenings ☐ Always about the same

Is it worse after activity? ☐ yes ☐ no

Have you ever experienced any injury to or symptoms involving this body part in the past? ☐ yes ☐ no
If so, please provide details: _____

What test have you had regarding this injury? ☐ **NONE** ☐ X-rays ☐ MRI ☐ CT scan ☐ Bone scan ☐ EMG/NCV ☐ Ultrasound ☐ Labs ☐ Other: _____

Have you had any treatment for this problem? ☐ **NONE** ☐ medication ☐ therapy ☐ splinting/brace ☐ injection ☐ surgery ☐ manipulation ☐ chiropractic treatment ☐ massage ☐ acupuncture ☐ pain specialist ☐ other: _____

- Was any of your treatment effective? Explain: _____

_____

- Where did you receive treatment? _____

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What is your pain scale today:	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
0=no pain 10=worst pain	RIGHT	LEFT

Put an X in the box that indicates your ability to do the following activities

ASES SCORE	RIGHT				LEFT			
	Unable to do	Very Difficult	Somewhat Difficult	Not Difficult	Unable to do	Very Difficult	Somewhat Difficult	Not Difficult
Put on a coat								
Sleep on your side								
Wash back/clip bra								
Manage toileting								
Comb hair								
Reach a high shelf								
Lift 10 pounds above shoulder								
Throw a ball overhand								
Do usual work Example:								
Do usual sport Example:								

Please answer the following questions for BOTH your AFFECTED and UNAFFECTED shoulder. Please do not leave any questions unanswered. Please make notes on the back of this page as necessary.

DASH SCORE	RIGHT		LEFT	
Is your shoulder comfortable with your arm at rest by your side?	Yes	No	Yes	No
Does your shoulder allow you to sleep comfortably?	Yes	No	Yes	No
Can you reach the small of your back to tuck in your shirt with your hand?	Yes	No	Yes	No
Can you place your hand behind your head with the elbow straight out to the side?	Yes	No	Yes	No
Can you place a coin on a shelf at the level of your shoulder without bending your elbow?	Yes	No	Yes	No
Can you lift 1 pound (one pint container) to the level of your shoulder without bending your elbow?	Yes	No	Yes	No
Can you lift 8 pounds (one gallon of milk) to the top of your head without bending your elbow?	Yes	No	Yes	No
Can you carry 20 pounds (a bag of potatoes) at your side?	Yes	No	Yes	No
Do you think you can toss a softball under-hand 10 yards?	Yes	No	Yes	No
Do you think you can toss a softball over-hand 20 yards?	Yes	No	Yes	No
Can you wash the back of the opposite shoulder?	Yes	No	Yes	No
Would your shoulder allow you to work full time at your regular job?	Yes	No	Yes	No

Patient Signature: _____

Provider Signature: _____ Date: _____