SHOULDER HISTORY

Name ______________________________ Age __________ Date ________________

Which shoulder is bothering you? Right / Left Dominant hand: R / L
Describe your shoulder problem ☐ Pain ☐ Stiffness ☐ Dislocation ☐ Other
When did you first notice this problem? ________________________________
Is it related to trauma? ________________________________
Is it related to work? ________________________________

Nature of your pain?

Where is it located? ________________________________
Does it radiate to the neck or arm? Yes / No. Describe ____________________
Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Stabbing ☐ Other ___________
Severity of pain when worse: rate from 1 – 10 (1 = hardly any pain to 10 = worst pain ever) ______
Pain aggravated by: ________________________________
Pain relieved by : ________________________________
List any associated symptoms:________________________________

Do you have any other shoulder symptoms?

	Yes	No
Cracking or Grinding	☐	☐
Catching or Locking	☐	☐
Weakness	☐	☐

Do you have any numbness, tingling or weakness in your arm or hand?

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Did you receive any treatment for your shoulder prior to this appointment?

	Yes	No
1. Injection	☐	☐
2. Therapy	☐	☐
3. Surgery	☐	☐
4. Other _______________	☐	☐

Diagnostic testing: X-Ray: Y / N MRI: Y / N EMG: Y / N

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Does your shoulder problem affect your job performance or recreational activities?

Do you have any other medical problem? Y / N If yes, what are they?

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Current Medications: ________________________________ Allergies:________________

Form/sheval/05