PERFORMANCE
ORTHOPAEDICS • SPORTS MEDICINE • SHOULDER SURGERY • PHYSICAL THERAPY
3701 Northwest Cary Parkway, Suite 305 • Cary, NC 27513 Ph (919) 882-6100 Fx (919) 877-4797

NEW PATIENT SHOULDER QUESTIONNAIRE

PLEASE ANSWER THE FOLLOWING QUESTIONS:

1. What is your Name?_____
2. What is your AGE? _____
3. What is your occupation? _____
4. RIGHT or LEFT shoulder? _____
5. Are you RIGHT or LEFT Handed? _____
6. Do you perform regular exercise? _____
7. When did your shoulder symptoms start? _____
8. Did you have a specific INJURY to your shoulder? (If so, please BRIEFLY describe)?

9. If so, was your injury WORK RELATED?

***PRIOR* TO YOUR CURRENT SHOULDER PROBLEMS…**

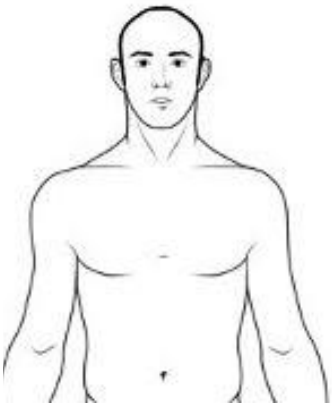
10. Have you had any previous shoulder PROBLEMS? (if so, please BRIEFLY describe)

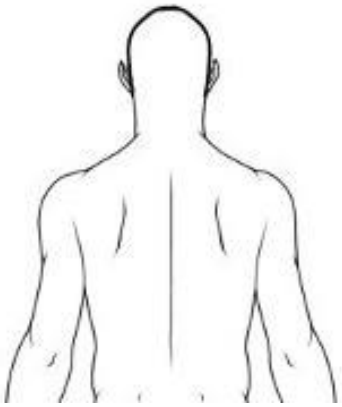
11. Have you had any previous shoulder INJURIES? (i.e. dislocation, fracture, etc.)

12. Have you had any previous shoulder SURGERY? (if so, please list along with dates)

YOUR SYMPTOMS:

13. WHERE does your shoulder hurt? (please mark the area)





14. Rate your pain on a scale of 1-10:

15. WHEN does your shoulder hurt? (circle all that apply)

All the time
Sleeping on the shoulder
Reaching overhead
Reaching behind you
Reaching across your body
Throwing
Lifting

- Please list any other activities that cause your shoulder to hurt:

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16. Does your shoulder make any noise while moving? (such as popping, clicking, crunching)?

17. Does your shoulder catch or lock?

18. Does your shoulder feel loose, or come out of joint?

19. Do you have reduced motion?

20. Do you have reduced strength?

21. Do you have numbness/tingling down your arm? (If yes, please describe where, i.e. forearm, hand, fingers)

22. Do you have pain down your arm? (If yes, please describe where, i.e. forearm, hand, fingers)

TREATMENT:

23. Have you had evaluation and/or treatment for your shoulder prior to today's office visit?

IF NO, please skip to **IMAGING** section below…

IF YES, please circle which treatment(s) you have had:

Shoulder exercises at home
Physical therapy
Cortisone injection
Surgery

- Please list any other treatments:

IMAGING:

24. Have you had imaging of your shoulder prior to today's office visit?

IF YES, please circle and describe results if you know them.

XRAY
ULTRASOUND
MRI

- Please list any other imaging: