Shoulder History and Physical Exam

Patient Name: Date:
Please Complete This Form To Help Us Better Evaluate And Treat Your Shoulder.
Age Race Sex Right Handed Left Handed Occupation
Right Shoulder Left Shoulder Date Of Injury/ Onset?
Chief Complaint (Describe Problem)
HISTORY Work Related? Sports Related?
Describe Injury or Trauma Event in Detail
Are you involved with Over-Head Work/ Activities/ Sports/ Hobbies?
Check Problems You Have With Your Shoulder
StiffnessSorenessSharp PainShiftingLoosenessCatchingLocking
WeaknessSwellingDislocatingNumbnessTinglingAching
Trouble Sleeping on ShoulderTrouble Sleeping Because of Shoulder
Athletics: Name of your sport?
Rate Your Pain On A Scale From 1 (Least) to 10 (Greatest).
X = Pain At Rest 0 = Pain With Activity Mark an X and O on the Line.
1 5 10
Previous Treatment:Primary M.DOrthopedic SurgeonPhysical Therapiss Name of M.D. or Therapist Change in Activities Medications For Problem
Physical Therapy How Long