SHOULDER QUESTIONAIRE
JAY KIMMEL M.D.

NAME_____ **DATE**_____

Have you or a family member been a previous patient of Dr. Kimmel? Yes No

REASON FOR VISIT

Right Shoulder_____ Left Shoulder _____ Both Shoulders_____

Date of Injury/Onset_____ Dominant Arm R L

What happened? Please be specific_____

LOCATION

Front of Shoulder	Yes	No
Top of Shoulder	Yes	No
Shoulder Blade	Yes	No
Collar Bone	Yes	No

SYMPTOMS

Pain at Night	Yes	No
Pain with Overhead Activity	Yes	No
Weakness	Yes	No
Stiffness	Yes	No
Shooting Pain down arm	Yes	No
Popping heard	Yes	No

Clicking/catching Yes No

PREVIOUS TREATMENT

Physical Therapy	Helped	Didn't Help	Have Not Tried
Cortisone Injection	Helped	Didn't Help	Have Not Tried
Medication	Helped	Didn't Help	Have Not Tried
Chiropractor	Helped	Didn't Help	Have Not Tried
Surgery	Helped	Didn't Help	Have Not Tried

Have you been treated by another physician for this problem ? Yes No

If yes Name _____ Date_____

Have you had X-Rays? Yes No When/Where_____

Have you an MRI ? Yes No When/Where_____