SHOULDER QUESTIONAIRE

Name _____ Date of Birth _____

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

IF THIS IS YOUR FIRST APPOINTMENT OR A NEW PROBLEM:

Left □ Right □ Both shoulders □

Incident occurred when: _____

Incident occurred where: Home □ Work □ Motor Vehicle Accident □

Other:_____

Injury Mechanism: Unknown □ Direct blow □ Fall □

Please explain the injury mechanism:

_____

Pain Location: Top □ Front □ Back □ Shoulder blade □ Collar bone □

Pain scale: 0 1 2 3 4 5 6 7 8 9 10

Pain course: Constant □ Intermittent □ Worsening □ Improving □

Associated Symptoms:

Pain with Overhead Activities □

Pain at night □

Loss of motion □

Stiffness □

Shooting pain down the arm □

Muscle weakness □

Aggravated by:

Nothing □

Movement/Activity □

Repetitive Activity □

Treatments tried:

Nothing	□	NSAID(Aleve,Advil)	□	Chiropractor	□
Heat	□	Tylenol	□	Physical Therapy	□
Ice	□	Rest	□	Surgery	□

Improvement on treatment: No relief□ Mild□ Moderate□ Significant□

Diagnostic Testing Xray _____ MRI _____

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

If yes, Name? _____ When? _____