Shoulder Patient Questionnaire
(To be completed by the patient)

Patient Name:_________________________ Examination Date:______/______/______

Involved/Worse Shoulder: ☐ Right
☐ Left

Exam Period: ☐ Pre-Treatment
☐ Post-Treatment (____months)

Your doctors are carefully evaluating the condition of your shoulder before and after treatment. Your responses to the following questions will help us gather important information that will improve our ability to offer high quality care to patients with shoulder injuries. For all questions, select one best answer.

Functional Assessment: Please describe your ability to perform the following activities.

	Involved/Worse Shoulder				Uninvolved/Better Shoulder			
	Unable to do	Very Difficult	Somewhat Difficult	Not Difficult	Unable to do	Very Difficult	Somewhat Difficult	Not Difficult
Use Back Pocket	☐	☐	☐	☐	☐	☐	☐	☐
Use Toilet Tissue	☐	☐	☐	☐	☐	☐	☐	☐
Wash Opposite Arm	☐	☐	☐	☐	☐	☐	☐	☐
Put on a Coat	☐	☐	☐	☐	☐	☐	☐	☐
Reach a High Shelf	☐	☐	☐	☐	☐	☐	☐	☐
Sleep on Affected Arm	☐	☐	☐	☐	☐	☐	☐	☐
Wash Back/Fasten Bra	☐	☐	☐	☐	☐	☐	☐	☐
Lift 10 lbs. Above	☐	☐	☐	☐	☐	☐	☐	☐
Shoulder	☐	☐	☐	☐	☐	☐	☐	☐
Usual Work Activities	☐	☐	☐	☐	☐	☐	☐	☐
Please list work activities: ________								
Do Usual Sport	☐	☐	☐	☐	☐	☐	☐	☐
Please list sport if applicable: ________								

Pain: Please indicate how much pain your shoulder usually feels by circling a point on the following line.

No Pain ____ **Severe Pain**

Please indicate what type of pain you are having: (Choose One)

☐Present all of the time and unbearable; strong medication frequently
☐Present all of the time but bearable; strong medication occasionally
☐None or little at rest, present during light activities; salicylates frequently
☐Present during heavy or particular activities only; salicylates occasionally
☐Occasional and slight
☐None

Function: On a scale of 0 to 10 with "0" meaning "my shoulder is useless" and "10" meaning "my shoulder is normal" please circle what you consider to be the current overall function of your shoulder.

Useless 0 1 2 3 4 5 6 7 8 9 10 **Normal**

Please indicate the type of activities you are able to do: (Choose One)

☐Unable to use limb

☐Only light activities possible

☐Able to do light housework or most activities of daily living

☐ Most housework, shopping and driving possible; able to do hair and dress and undress, including fastening brassiere

☐Normal activities

Satisfaction: Please indicate the overall satisfaction of the patient. (Post-op Only)

☐ Satisfied/Better ☐ Not Satisfied/Worse