SHOULDER HISTORY

NAME:_____DOB: _____ DATE:_____
Please print: First name, middle initial, last name

How old are you? _____ What is your occupation? _____ Height _____ Weight _____

Where do you live (City, State)? _____

Who may we thank for your referral to our office? _____ Physician or Patient (circle one)

Shoulder experiencing difficulty? ____Right ____Left ____Both, which is worse_____ Dominance? ___Right ___Left

On what date did your symptoms begin? _____ If unknown how long have you been experiencing difficulty with your arm? _____

What do you think may have caused your arm symptoms (spontaneous, overuse, exercise, specific injury, an accident)
_____

Describe how you were injured: _____
_____

Please mark all that apply by ranking them in order of decreasing severity with one (1) as most significant symptom.

Which of the following arm symptoms are you experiencing?
____Pain ____Locking/catching ____Weakness ____Instability/slipping sensation
____Stiffness ____Grinding/popping ____Swelling ____Numbness/Tingling

Where do you experience the majority if your arm pain?
____Front of your shoulder ____Top of your shoulder ____Inner side of your shoulder
____Back of your shoulder ____Generalized Pain ____Outer side of your shoulder

Does your shoulder pain radiate (move) ____No
____Down your arm ____Up your neck ____Into the front of chest ____Into upper back/shoulder blade

Please check all that apply to your shoulder discomfort:
____Aching ____Constant ____Burning
____Sharp ____Intermittent ____Present only with certain activities

Please mark the severity of your shoulder discomfort on a scale I----------I----------I
1 Minimal 5 Moderate 10 severe

Do you experience difficulty reaching or moving your shoulder in any of the following directions?
____Overhead ____Behind your back ____Out to the side ____Forward ____Across your chest ____All

Does your arm problem interfere with any of the following?
____ Daily Activities ____ School Activities ____Work Activities ____Recreation or Sports ____Sleeping

Has your arm been evaluated by: ____Primary Care Physician ____Another Orthopedic Surgeon ____E.R. Visit

Have you had any of the following imaging studies for your arm? Please include dates and facility, if known.
____X-ray date: _____ facility: _____ ____MRI date: _____ facility:_____
____CT scan date: _____ facility: _____ ____EMG/NCV date: _____ facility:_____
____Bone scan date: _____ facility: _____ _Other_____ date: _____ facility:_____

Please check any treatments that you tried for your arm condition?

____Rest	Did it help ____Yes____No	____Ice Application	Did it help ____Yes____No
____Anti-inflammatory	Did it help ____Yes____No	____Cortisone injection	Did it help ____Yes____No
____Exercise	Did it help ____Yes____No	____Acupuncture	Did it help ____Yes____No
____Physical therapy	Did it help ____Yes____No	____Chiropractic	Did it help ____Yes____No
____Brace/Sling	Did it help ____Yes____No	__Other_____	Did it help ____Yes____No

How is your arm progressing? ____Getting better ____Staying the same ____Getting worse

Have you ever had any significant arm injuries or require arm surgery in the past? ____Yes___No
If Yes, please explain and list prior dates, physicians, and any procedures: _____
_____
_____

Name_____Chart #_____ **PHYSICAL EXAM: TO BE COMPLETED BY PROVIDER**

PE: Height:_____ Weight:_____ ❍Ambulates ❍walker ❍cane ❍WC

Skin: ❍WNL ❍Lesions: _____

Pulses: ❍2+distal ❍diminished

C-Spine: ROM ❍Full ❍limited all planes ❍Tenderness to ❍Trap R L ❍Spinous process ❍WNL ❍Negative Spurling ❍Positive Spurling head to R L B ❍Causes neck pain

Hands: ❍WNL ❍LROM ❍arthritic *Wrists*: ❍WNL ❍LROM ❍+Tinels sign

Elbows: ❍WNL ROM: Exten_____ Flex_____ Pro_____ Sup_____

Strength: R ___/5 L___/5 + Tenderness ❍ Lateral condyle ❍Medial condyle

TEST: ❍ positive for lateral epicondylitis ❍positive for medial epicondylitis. ❍+cubital tun sign

Shoulders: *Inspection*: ❍WNL ❍+popeye sign R L B

Tenderness ❍ACJ R L ❍ LHBT R L ❍SCJ R L ❍GT tend R L ❍Crepitus R L

AROM/Impingement

***FF		***AB		***ER0		***IR	
R	L	R	L	R	L	R	L
☐	☐	☐	☐	☐	☐	☐	☐

Strength 0-No contraction 1-Flicker 2- Movement with gravity eliminated 3- Movement against gravity 4-Movement against some resistance 5- Normal Power *(Add P for painful)*

FF		AB ("Full Can")		Jobe's AB		ER_0		IR_0	
R	L	R	L	R	L	R	L	R	L
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Lift off: R_____ L_____ Belly Press: R_____ L_____

PROM

FF		AB		ER_{90}		IR_{90}		ER_0		AD	
R	L	R	L	R	L	R	L	R	L	R	L
☐	☐							☐	☐		

TEST: Painful arc: R L FF ABD O'Brien: R L Speed's: R L Yergason's: R L Hawkins: R L Neer R L
ER Lag Sign: R L Hornblower: R L Roos: R L
Increased translation: ❍anterior R L ❍posterior R L
Apprehension test: R L Relocation: R L Load & shift: R L
Kim: R L Jerk: R L Sulcus sign: R L Gagey: R L Beighton ____ / 9

PMH: □ Reviewed Intake Form □ DVT/PE Negative □ DVT/PE Positive

MEDS: _____

ALLERGIES: □ NKDA □ Positive:

PSH: _____

SH: □ Married □ Partnered □ Single

Occupation:_____ □ Retired □ Disabled

Tobacco: ETOH: THC/drugs: Activities/Hobbies: _____

_____

XRAY: _____

MRI: _____

Assessment: _____

Plan: _____

F/U_____