SHOULDER PAIN QUESTIONNAIRE

Patient Name: _____ **Date:** _____

How long have you had shoulder pain?

Check the words which describe your shoulder problem:

☐Pain ☐Stiffness ☐Weakness ☐Loss of Mobility ☐Numbness ☐Tingling

Did you hurt your shoulder in an accident? Yes / No
Did you fall on an outstretched arm? Yes / No
Did you land on top of your shoulder? Yes / No
Did you have your arm pulled up and back? Yes / No
Does your arm get caught in positions that you can click back into place? Yes / No
Other:

Do you preform repetitive activities with your shoulder? Yes / No
Do you work in overhead positions? Yes / No
Is it worse with lifting weights? Yes / No
Does your shoulder give out? Yes / No
Describe other repetitive activities:

Is there any associated neck pain? Yes / No
Have you had any trauma to your neck? Yes / No
Is the pain in your neck connected to pain in your shoulder? Yes / No

Are there other problems that occur at the same time as your shoulder pain? Yes / No
Do you have any stomach pains? Yes / No
Do you feel gassy and / or bloated? Yes / No
Do you experience any chest pain? Yes / No

Is your shoulder complaint more of stiffness? Yes / No
Do you have a past history of trauma? Yes / No
Did the stiffness get worse after a few weeks of pain? Yes / No

Is there a sense of weakness or instability? Yes / No
Does it feel weak with your arm elevated? Yes / No

Have you ever been diagnosed with any kinds of arthritis in the past? Yes / No
Do you have any other joint pains? Yes / No
Please describe your arthritis:

Is your shoulder pain associated with any symptoms in your arm? Yes / No
If yes, please describe:

Are you experiencing shoulder pain with no specific mechanical exacerbating or Remitting factors? Yes / No

What specifically aggravates your shoulder pain?

☐Coughing	☐Sneezing	☐Bowel Movements	☐Lifting/Moving Arm
☐Lifting Weights	☐Moving Shoulder	☐Computer Work	☐Sleeping on Shoulder
☐Swimming	☐Throwing	☐Driving Car	☐Other, describe:

What specifically alleviates your shoulder pain?

☐Nothing ☐Lying Down ☐Hot Packs ☐Cold Packs ☐Massage ☐Manipulation
☐Exercise ☐Stretching ☐Traction ☐Electrical Stimulation ☐Ultrasound
☐Medications, describe:
☐Resting in specific positions, describe:
☐Other, describe:

How would you describe your shoulder pain?

☐Dull ☐Aching ☐Burning ☐Sharp/Stabbing ☐Electrical
☐Pins/Needles ☐Deep ☐Superficial ☐Tingling ☐Numbing
☐Other, describe:

Does your shoulder pain spread? Yes / No

If it spreads, where does it start and where does it go?

If it is pin point pain, where is it?

On a scale of 1 to 10, 1 being very minimal pain and 10 being the worst pain you can imagine, circle how you would rate your shoulder pain:

At its best: 0-------1-------2-------3-------4-------5-------6-------7-------8-------9-------10
At its worst: 0-------1-------2-------3-------4-------5-------6-------7-------8-------9-------10
On average: 0-------1-------2-------3-------4-------5-------6-------7-------8-------9-------10

What % of the time do you experience your shoulder pain?

Daily: 0%----------25%----------50%----------75%----------100%
Weekly: 0%----------25%----------50%----------75%----------100%
Monthly: 0%----------25%----------50%----------75%----------100%

Does your shoulder pain interfere with your ability to:

☐Sleep, describe:

☐Work, describe:

☐Exercise, describe:

☐Other, describe:

At what time of the day is your shoulder pain at its worst?

At what time of the day is your shoulder pain at its best?

Have you experienced this pain in your shoulder before? Yes / No

History of Previous Evaluations / Treatments for Your Shoulder Pain

Who have you seen previously for your shoulder pain? Describe who, when, diagnosis and treatment previously received:

Have you received any special tests previously for your shoulder pain i.e. MRI, X-ray? Describe:

Which previous treatment(s) did you find most beneficial?

Which previous treatment did you find least beneficial?

What do you think is causing your shoulder pain?