

SHOULDER SURVEY

Name: _____ Date: ____/____/____ Date of Birth: ____/____/____
Last First MI

Gender: Male Female Dominant Hand: Right Left Problem Shoulder: Right Left Job Injury: Yes No

Occupation: _____ Date last worked: ____/____/____ Legal Claim: Yes No

How bad is your pain **today**?

0 1 2 3 4 5 6 7 8 9 10
 No pain at all Worst pain imaginable

Which word below best describes your pain?

None Moderate
 Mild Severe

Please select the statement that best describes your shoulder:

I have no pain
 I have slight pain during activity
 I have increased pain during activities
 I have moderate/severe pain with activity
 I have severe pain and need medication

	Yes	No		0=unable to do 2=somewhat difficult	1=very difficult to do 3=not difficult		
<input type="checkbox"/>	<input type="checkbox"/>		Is your shoulder comfortable with your arm at rest by your side?				
<input type="checkbox"/>	<input type="checkbox"/>		Does your shoulder allow you to sleep comfortably?			Right arm	Left arm
<input type="checkbox"/>	<input type="checkbox"/>		Can you reach the small of your back to tuck in your shirt?			0 1 2 3	0 1 2 3
<input type="checkbox"/>	<input type="checkbox"/>		Can you place your hand behind your head with the elbow straight out to the side?			0 1 2 3	0 1 2 3
<input type="checkbox"/>	<input type="checkbox"/>		Can you place a coin on a shelf at the level of your shoulder without bending your elbow?			0 1 2 3	0 1 2 3
<input type="checkbox"/>	<input type="checkbox"/>		Can you lift one pound (a full pint container) to the level of your shoulder without bending your elbow?			0 1 2 3	0 1 2 3
<input type="checkbox"/>	<input type="checkbox"/>		Can you lift 8 lbs. (a full gallon container) to the level of your shoulder without bending your elbow?			0 1 2 3	0 1 2 3
<input type="checkbox"/>	<input type="checkbox"/>		Can you carry 20 lbs. at your side with your affected arm?			0 1 2 3	0 1 2 3
<input type="checkbox"/>	<input type="checkbox"/>		Can you toss a ball underhand 10 yards with your affected arm?			0 1 2 3	0 1 2 3
<input type="checkbox"/>	<input type="checkbox"/>		Can you throw a ball overhand 20 yards with your affected arm?			0 1 2 3	0 1 2 3
<input type="checkbox"/>	<input type="checkbox"/>		Can you wash the back of your opposite shoulder with your affected arm?			0 1 2 3	0 1 2 3
<input type="checkbox"/>	<input type="checkbox"/>		Would your shoulder allow you to work full time at your usual job?			0 1 2 3	0 1 2 3

Please select the **ONE** statement that best describes your injured shoulder's function.

- Normal function.** I can do all activities of daily living, work and sports activities that I did before my injury (lifting 30 or more pounds, throwing, tennis, swimming).
- I have **mild limitations** in sports and work. I can throw but limited, can lift 15-20 pounds, able to wash back, comb hair and get dressed.
- I have **moderate limitations** in overhead work, sports and lifting (10 pounds). Unable to throw or serve in tennis. Have difficulty with washing back, combing hair or getting dressed (need help sometimes).
- I have **severe limitations**. Cannot do usual work or lifting. No sports. Need help washing and dressing. Can feed myself and comb hair.
- Complete disability** of arm.

Please rate how your shoulder problem affects your ability to work.

4 Fully able to work
 3
 2
 1
 0 Unable to work

Please rate how your shoulder problem affects your ability to participate in sports or recreational activities.

4 Fully able to participate
 3
 2
 1
 0 Unable to participate

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Please choose the highest level you are able to use your hands to perform tasks:

- Can use hands only at waist level
- Can use hands at chest level
- Can use hands at neck level
- Can use hands to the top of my head
- Can use hands at levels over my head

CURRENT HEALTH ASSESSMENT

In general, would you say your health is:

- Excellent
- Very Good
- Good
- Fair
- Poor

The following items are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?

	Yes, limited a lot	Yes, limited a little	No, not limited at all
Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climbing several flights of stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

	Yes	No
Accomplished less than you would like	<input type="checkbox"/>	<input type="checkbox"/>
Were limited in the kind of work or other activities	<input type="checkbox"/>	<input type="checkbox"/>

During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of emotional problems (such as feeling anxious or depressed)?

	Yes	No
Accomplished less than you would like	<input type="checkbox"/>	<input type="checkbox"/>
Didn't do work or other activities as carefully as usual	<input type="checkbox"/>	<input type="checkbox"/>

During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?

- Not at all Quite a bit
- A little bit Extremely
- Moderately

These questions are about how you feel and how things have been with you during the last 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling. How much of the time during the last 4 weeks:

	All of <u>the time</u>	Most of <u>the time</u>	A good bit <u>of the time</u>	Some of <u>the time</u>	A little of <u>the time</u>	None of <u>the time</u>
Have you felt calm and peaceful?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did you have a lot of energy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you felt downhearted and blue?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting friends, relatives, etc.)?

- All of the time Most of the time Some of the time A little of the time None of the time

Thank you for completing this information!

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