

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_

DOB: \_\_\_\_\_

**Patient Medical History for SHOULDER Symptoms**

Referred by: \_\_\_\_\_ Date of Injury/Onset of Symptoms: \_\_\_\_\_

**Reason for visit:** Describe injury or onset in detail: Left Right \_\_\_\_\_

**Pain:** Sharp Dull Stabbing Burning Other: \_\_\_\_\_

**Pain:**  Constant  Intermittent

**On a scale of 0 – 10, 0 being useless and 10 being normal, CIRCLE the most current OVERALL FUNCTION of your problematic joint or limb.**      0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

**Intensity of Pain AT REST (circle):**      0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

**Intensity of Pain WITH ACITIVITY (circle):**      0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

- 0 – No Pain
- 1 – Mild Pain, you are aware of the pain, but it does not bother you
- 2 – Moderate Pain – You can tolerate pain without medication
- 3 – Moderate Pain – Requires Medication to tolerate pain
- 4 – 5 – More Severe Pain – you begin to feel anti-social
- 6 – Severe Pain
- 7 – 9 - Intensely Severe Pain
- 10 – Most Severe Pain, Emergency Room Care

**Location (describe):** \_\_\_\_\_

**Does the Pain go anywhere else (describe)?** \_\_\_\_\_

**What makes the pain worse?** Pushing Pulling Reaching Overhead Across Body Behind Back  
Sleeping Driving Throwing Lifting Weights Other? \_\_\_\_\_

**What makes pain Better?** Rest Activity Modification Ice/Heat Meds  
Other: \_\_\_\_\_

**What other symptoms are present?** Catching Popping Grinding Locking Dislocation  
Subluxation Swelling (Constant Fluctuates)

**Have you received an injection in your current problem area?** NO YES If YES, when? \_\_\_\_\_

**What treatments have you attempted and what effect (PT, Meds)?** \_\_\_\_\_

**Can you work or participate in sports with current symptoms?** NO YES

**Do you have light duty available at work?** NO YES