Shoulder Intake Form

By answering the following questions, your doctor will have a better idea about your baseline level of function, and can help determine your improvement after treatment. We appreciate you answering each question – even though we know some are repetitive!

How bad is your pain today? (0 = "no pain at all" and 100 = "pain as bad as it can be") _____

Circle the number in the box that indicates your ability to do the following activities:
0 = Unable to do **1** = Very difficult to do **2** = Somewhat difficult **3** = Not difficult

Activity	Right arm	Left arm
Put on a coat	0 1 2 3	0 1 2 3
Sleep on your painful or affected side	0 1 2 3	0 1 2 3
Wash back / fasten bra in back	0 1 2 3	0 1 2 3
Manage toileting	0 1 2 3	0 1 2 3
Comb hair	0 1 2 3	0 1 2 3
Reach to a high shelf	0 1 2 3	0 1 2 3
Lift 10 pounds above shoulder	0 1 2 3	0 1 2 3
Throw a ball overhead	0 1 2 3	0 1 2 3
Do usual work – List:	0 1 2 3	0 1 2 3
Do usual sport/hobby – List:	0 1 2 3	0 1 2 3

1. Is your shoulder comfortable with your arm at rest by your side? Y or N
2. Does your shoulder allow you to sleep comfortably? Y or N
3. Can you reach the small of your back to tuck in your shirt with your hand? Y or N
4. Can you place your hand behind your head with the elbow straight out to the side? Y or N
5. Can you place a coin on a shelf at the level of your shoulder without bending your elbow? Y or N
6. Can you lift one pound (a full pint) to the level of your shoulder without bending your elbow? Y or N
7. Can you lift eight pounds (a full gallon) to the level of the top of your head without bending your elbow? Y or N
8. Can you carry 20 pounds at your side with the affected extremity? Y or N
9. Do you think you can toss a softball underhand 10 yards with the affected extremity? Y or N
10. Do you think you can throw a softball overhand 20 yards with the affected extremity? Y or N
11. Can you wash the back of your opposite shoulder with the affected extremity? Y or N
12. Would your shoulder allow you to work full-time at your usual job? Y or N

Please indicate with an "X" how often you performed each activity in your healthiest and most active state, **in the past year.**

	Never or less than once a month	Once a month	Once a week	More than once a week	Daily
Carrying objects 8 pounds or heavier by hand (such as a bag of groceries)					
Handling objects overhead					
Weight lifting or weight training with arms					
Swinging motion (as in hitting a tennis ball, baseball, golf ball, or similar)					
Lifting objects 25 pounds or heavier (such as 3 gallons of water) NOT INCLUDING WEIGHT LIFTING					

For each of the following questions, please circle the letter that best describes your participation in that particular activity.

1. Do you participate in contact sports (such as, but not limited to, football, rugby, soccer, basketball, wrestling, boxing, lacrosse, etc…)

   A No **B** Yes, **without** officiating **C** Yes, **with** officiating **D** Yes, at a professional level

2. Do you participate in sports that involve hard overhand throwing (such as baseball, cricket or football quarterback), overhead service (such as tennis or volleyball), or lap/distance swimming?

   A No **B** Yes, **without** officiating **C** Yes, **with** officiating **D** Yes, at a professional level