



COASTAL ORTHOPEDICS & SPORTS MEDICINE

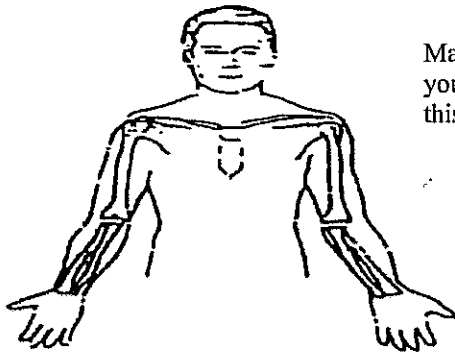
SHOULDER ASSESSMENT FORM

American Shoulder and Elbow Surgeons

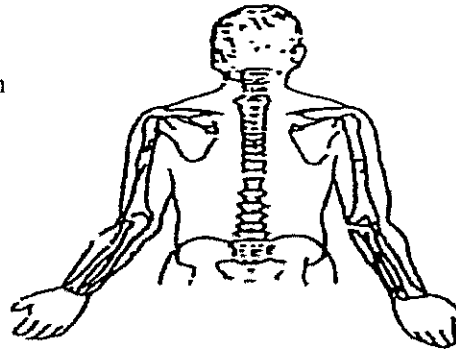
Name: _____		Date: _____	
Right Handed	Left Handed	Gender: Male	Female
Date of Birth: _____		Age: _____	

PATIENT SELF-EVALUATION

Are you having pain in your shoulder?	YES	NO
Do you have pain in your shoulder at night?	YES	NO
Do you take pain medication (aspirin, Advil, Tylenol, etc)?	YES	NO
Do you take narcotic pain medication (codeine or stronger)?	YES	NO
How many pills do you take each day (average)?	_____ pills	
Does your shoulder feel unstable (as if it is going to dislocate)?	YES	NO



Mark where your pain is on this diagram



How bad is your pain today (mark line)?

0 | _____ | 10

No Pain Extreme Pain

How unstable is your shoulder (mark line)?

0 | _____ | 10

Very Stable Very UNstable

Circle the number in the box that indicates your ability to do the following activities:
 0= **Unable** to do; 1= **Very Difficult**; 2= **Somewhat Difficult**; 3= **Normal**

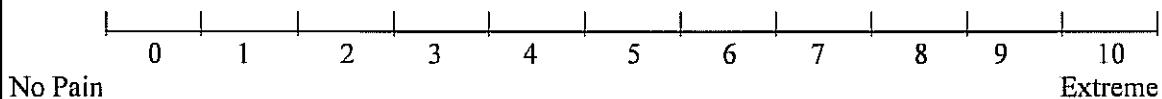
ACTIVITY	Right Arm	Left Arm
1. Use Back Pocket	0 1 2 3	0 1 2 3
2. Use Toilet Tissue	0 1 2 3	0 1 2 3
3. Wash Opposite Armpit	0 1 2 3	0 1 2 3
4. Eat with Utensil	0 1 2 3	0 1 2 3
5. Comb/Wash Hair	0 1 2 3	0 1 2 3
6. Dress with Hand	0 1 2 3	0 1 2 3
7. Sleep on Affected Arm	0 1 2 3	0 1 2 3
8. Lifting	0 1 2 3	0 1 2 3
9. Work Activities/ Housework	0 1 2 3	0 1 2 3
10. Participation in Sports/ Walking	0 1 2 3	0 1 2 3

Patient Assessment:

Pain

On the following scale of 0-10, please mark the average amount of pain you experience in your shoulder on a daily basis.

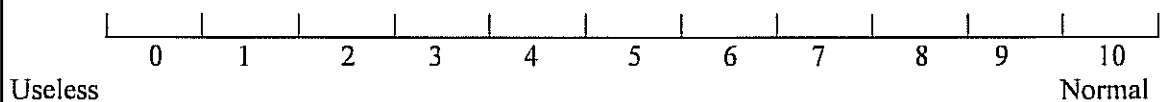
0 = No Pain
 10 = Extreme Pain



Function

On the following scale of 0-10, please mark what you consider to be current overall function of your shoulder.

0 = my shoulder is useless
 10 = my shoulder is normal



Answer each question below by checking Yes or No

	Yes	No
1. Is your shoulder comfortable with your arm at rest by your side?		
2. Does your shoulder allow you to sleep comfortably?		
3. Can you reach the small of your back to tuck your shirt with your hand?		
4. Can you place your hand behind your head with the elbow straight out to the side?		
5. Can you place a coin on the shelf at the level of your shoulder without bending your elbow?		
6. Can you lift one pound (a full pint container) to the level of your shoulder without bending your elbow?		
7. Can you lift eight pounds (a full gallon container) to the level of your shoulder without bending your elbow?		
8. Can you carry twenty pounds at your side with the affected extremity?		
9. Do you think you can toss a softball over-hand twenty yards with the affected extremity?		
10. Do you think you can toss a softball under-hand twenty yards with the affected extremity?		
11. Can you wash the back of your opposite shoulder with the affected extremity?		
12. Would your shoulder allow you to work full-time at your regular job?		

SF-36 Questionnaire

Instructions: Thank you in advance for taking the time to fill this questionnaire out. This questionnaire is about YOU and how YOU feel your physical health affects other aspects of your life. There are no right or wrong answers. Please read each question carefully, and answer as honestly as you can. Circle the ONE response which YOU feel represents YOUR feelings.

1. In general, would you say your health is:

- Excellent
 Very Good
 Good
 Fair
 Poor

2. Compared to one year ago, how would you rate your health in general now?

- Much better now than one year ago
 Somewhat better now than one year ago
 About the same as one year ago
 Somewhat worse now than one year ago
 Much worse now than one year ago

3. 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 |
|---|--------------------------|--------------------------|--------------------------|
| a. Vigorous activities, such as running, lifting heavy objects, participating in strenuous sports? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Lifting or carrying groceries? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Climbing several flights of stairs? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Climbing one flight of stairs? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Bending, kneeling, or stooping? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Walking more than one mile? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Walking several blocks? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Walking one block? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| j. Bathing or dressing yourself? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

4. 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?

- | | All Of
The Time | Most Of
The Time | Some Of
The Time | A Little Of
The Time | None Of
The Time |
|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| a. Cut down the amount of time you spent on work or other activities? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Accomplished less than you would like? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Were limited in the kind of work or other activities? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Had difficulty performing the work or other activities (for example, it took extra effort)? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

5. 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 any emotional problems (such as feeling depressed or anxious)?

- | | All Of
The Time | Most Of
The Time | Some Of
The Time | A Little Of
The Time | None Of
The Time |
|---|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| a. Cut down the amount of time you spent on work or other activities? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Accomplished less than you would like? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Did work or other activities less carefully than usual? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

6. During the past 4 weeks, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbors, or groups?
 Not At All Slightly Moderately Quite A Bit Extremely

7. How much bodily pain have you had during the past 4 weeks?
 None Very Mild Mild Moderate Severe Very Severe

8. 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 A Little Bit Moderately Quite A Bit Extremely

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

	All Of The Time	Most Of The Time	Some Of The Time	A Little Of The Time	None Of The Time
a. Did you feel full of pep?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Have you been very nervous?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Have you felt down in the dumps?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Have you felt calm and peaceful?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Did you have a lot of energy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Have you felt downhearted and blue?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Did you feel worn out?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Have you been happy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Do you feel tired?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

10. During the past 4 weeks, how much of your time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives, etc.)
 All Of The Time Most Of The Time Some Of The Time A Little Of The Time None Of The Time

11. How true or false is each of the following statements for you?

	Definitely True	Mostly True	Don't Know	Mostly False	Definitely False
a. I seem to get sick a little easier than other people.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. I am as healthy as anybody I know.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. I expect my health to get worse.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. My health is excellent.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>