Patient INTAKE Survey
Shoulder

Name:	Date:
Date of Birth:	Sex:

Today, how much does or would the problem for which you are seeking attention limit:	Extreme Difficulty	Quite a Bit of Difficulty	Moderate Difficulty	A Little Bit of Difficulty	No Difficulty
1. Combing or brushing your hair using your affected arm?					
2. Using your affected arm to place a can of soup (1lb) on a shelf at shoulder height?					
3. Using your affected arm to pick up and drink out of a full glass of water?					
4. Using your affected arm to reach a shelf that is at shoulder height?					
5. Using your affected arm to reach an overhead shelf?					
6. Pushing yourself out of a chair using both arms?					
7. Reaching across to the middle of the table with your affected arm to get a salt shaker while sitting?					
8. Getting a scarf or necktie over your head and around your neck, using both hands?					
9. Putting on deodorant using your affected shoulder?					
10. Pulling a chair out from a table using your affected arm?					

11.) Please indicate the amount of pain you have had in the last 24 hours (circle one):

No Pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as it can be

12.) How many surgeries have you had for this condition? __________________

13.) How many days ago did this condition begin? ______________________________

14.) Are you taking prescription medication for this condition? ____________________

15.) Have you received treatment for this condition before? _______________________

16.) I am apprehensive about doing physical activities which might make my pain worse (circle one).

Completely disagree 1 2 3 4 5 6 7 Completely agree

17.) How often have you completed at least 20 minutes of exercise such as jogging, cycling or brisk walking prior to the onset of your condition?

____3 or more times per week _____Once or twice a week _____Seldom or Never

18.) What is your present employment status? (Mark one)

_____Employed and presently working full duty at same job
_____Employed and presently working full duty at different job
_____Employed and presently working restricted duty at same job
_____Employed and presently working restricted duty at different job
_____Employed but presently not working due to my condition
_____Previously employed and receiving disability benefits for my condition
_____Unemployed
_____Retired
_____Student
_____Other

19.) Other health problems may affect your treatment. Please check any of the following that apply:

_____Arthritis (rheumatoid/osteoarthritis)	_____Visual Impairment
_____Osteoporosis	_____Hearing Impairment
_____Asthma	_____Back Pain
_____Chronic Obstructive Pulmonary Disease or emphysema	_____Kidney, Bladder, Prostate or Urination Problems
_____Angina	_____Allergies (medication, latex)
_____Congestive Heart Failure (heart disease)	_____Incontinence
_____Heart Attack (Myocardial Infarction)	_____Anxiety or Panic Disorder
_____High Blood Pressure	_____Depression
_____Neurological Disease (Multiple Sclerosis, Parkinson's)	_____Other disorders
_____Stroke or TIA	_____Hepatitis/AIDS
_____Peripheral Vascular Disease	_____Sleep dysfunction
_____Headaches	_____Cancer
_____Diabetes	_____Fatigue
_____Gastrointestinal Disease (ulcer, hernia, reflux, bowel, liver, gallbladder)	_____ Fever/Chills/Sweats
_____Nausea/Vomiting	_____Numbness or Tingling
_____Weight Loss/Gain	_____Muscle Weakness
	_____Dizziness/Lightheadedness
	_____Difficulty with balance while walking
	_____Falls

Please list all medications you are currently taking:	**Please list all surgeries you have had:**