PATIENT FORM

Shoulder Assessment Form

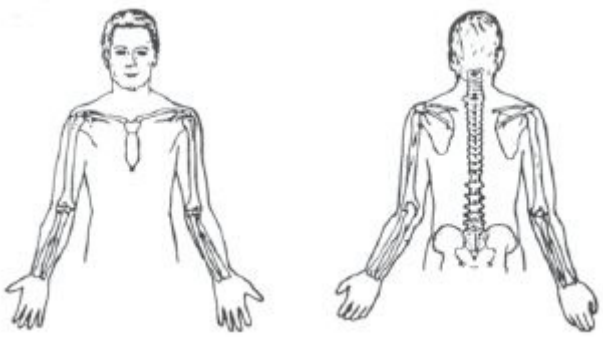
American Shoulder and Elbow Surgeons

Name:		Date:
Age:	Hand Dominance: R L Ambi	Sex: M F
Diagnosis:		Initial Asses? Y N
Procedure/Date:		Follow-up: M; Y

PATIENT SELF-EVALUATION

Are you having pain in your shoulder (circle correct answer)	Yes	No

Mark where your pain is



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	

How bad is your pain today (mark line)?

No pain at all — Pain as bad as it can be

Does your shoulder feel unstable (as if it is going to dislocate)?	Yes	No

How unstable is your shoulder (mark line)

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 to do; 2 = Somewhat difficult; 3 = **Not** difficult

ACTIVITY	RIGHT ARM	LEFT ARM
1. Put on a coat	0 1 2 3	0 1 2 3
2. Sleep on your painful or affected side	0 1 2 3	0 1 2 3
3. Wash back/do up bra in back	0 1 2 3	0 1 2 3
4. Manage toileting	0 1 2 3	0 1 2 3
5. Comb hair	0 1 2 3	0 1 2 3
6. Reach a high shelf	0 1 2 3	0 1 2 3
7. Lift 10 lbs. above shoulder	0 1 2 3	0 1 2 3
8.Throw a ball overhead	0 1 2 3	0 1 2 3
9. Do usual work – List:	0 1 2 3	0 1 2 3
10. Do usual sport –List:	0 1 2 3	0 1 2 3