

Name _____

GREATER HARTFORD ORTHOPEDICS

Dr. Jay Kimmel Shoulder Questionnaire

Shoulder Right _____ Left _____ Dominant hand-Right _____ Left _____

Date of Injury/Onset of pain _____

Please describe your injury/onset of pain

Please circle your response

Pain at night Yes No

Pain with overhead activities Yes No

Pain doing sports/exercise Yes No

Pain ALL the time Yes No

Numbness or Tingling Yes No

XRays taken Yes No

MRI Yes No

Previous Treatment Yes No

Medications? List _____

Cortisone Injections Yes No

Physical Therapy Yes No

Surgery Yes No Date _____

Have you treated with another M.D. for this problem? Yes No

Name M.D. _____

Previous patient of Dr. J. Kimmel Yes No