

SHOULDER – FOLLOW UP

Name: _____ **DOB:** _____

Side: LEFT RIGHT

Progression: worsening improving unchanged / same

Imaging/testing since last visit: MRI Xrays CT EMG Bone Scan

Physical Therapy: Yes No **Where:** _____

Improvement: Yes No Gradual Rapid

Location of pain: Front Back Side
 Scapular Biceps Triceps Coracoid Clavicle AC Joint

Type of pain: Burning Dull/Aching Sharp Shooting Stabbing
 Throbbing Pinching Diffuse Localized Radiating

Associated symptoms:

Numbness: Yes No

Tingling: Yes No

Tightness: Yes No

Instability: Yes No

Do you feel: Clicking Catching Locking Weakness

Does pain radiate: Yes, radiates to _____ No

Limitations to daily activity: Yes No

Limitations to sports/exercise: Yes No

Pain at rest Yes No

If YES, on a 0 to 10 scale (0 being none and 10 being worst), how would you rate it?

0 1 2 3 4 5 6 7 8 9 10

Current severity of pain: none mild moderate severe

On a 0 to 10 scale, how would you rate your pain right now:

0 1 2 3 4 5 6 7 8 9 10

Do you feel pain with activity? Yes No

If YES, on a 0 to 10 scale, how would you rate your pain with activity?

0 1 2 3 4 5 6 7 8 9 10

Current work status: Regular Duty Light Duty Not working due to this injury
 Student Disabled Retired Unemployed

Treatments:	Helpful?	Not Tried:
Physical Therapy:	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/>
Cortisone injection:	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/>
NSAIDs:	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/>
Chiropractor:	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/>
Ice:	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/>
Heat:	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/>
Massage:	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/>
Acupuncture:	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/>
Home exercise program:	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/>
Bracing:	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/>
Topical rubs:	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/>

REVIEW OF SYSTEMS (Please Circle all that apply)

Abdominal pain/discomfort	Abnormal Menstrual periods	Back Pain	Chest Pain
Chills	Constipation	Depression	Diarrhea
Double Vision	Easy Bruising	Environment Allergies	Fatigue
Fever	Glasses	Headaches	Incontinence
Joint Pain (Arthralgia)	Leg swelling/pain	Neck Pain	Neck Stiffness
Nervousness/Anxiety	Numbness	Rash	Shortness of Breath

None of the Above