

Inland Orthopaedic Surgery and Sports Medicine Clinic

Appointment Date _____

Doctor's Signature _____

Patient Name _____

Birthdate _____

PROBLEMS WITH YOUR SHOULDER

Tick (✓) one box for every question.

1. During the past 4 weeks...

How would you describe the **worst** pain you had from your shoulder?

None

Mild

Moderate

Severe

Unbearable

2. During the past 4 weeks...

Have you had any trouble dressing yourself because of your shoulder?

No trouble
at all

A little bit of
trouble

Moderate
trouble

Extreme
difficulty

Impossible
to do

3. During the past 4 weeks...

Have you had any trouble getting in and out of a car or using public transport because of your shoulder?

No trouble
at all

A little bit of
trouble

Moderate
trouble

Extreme
difficulty

Impossible
to do

4. During the past 4 weeks...

Have you been able to use a knife and fork - at the same time?

Yes,
easily

With little
difficulty

With
moderate
difficulty

With extreme
difficulty

No,
impossible

5. During the past 4 weeks...

Could you do the household shopping on your own?

Yes,
easily

With little
difficulty

With
moderate
difficulty

With extreme
difficulty

No,
impossible

6. During the past 4 weeks...

Could you carry a tray containing a plate of food across a room?

Yes,
easily

With little
difficulty

With
moderate
difficulty

With extreme
difficulty

No,
impossible

7. During the past 4 weeks...

Could you brush/comb your hair with the affected arm?

Yes, easily	With little difficulty	With moderate difficulty	With extreme difficulty	No, impossible
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

8. During the past 4 weeks...

How would you describe the pain you usually had from your shoulder?

None	Very mild	Mild	Moderate	Severe
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

9. During the past 4 weeks...

Could you hang your clothes up in a wardrobe, using the affected arm?

Yes, easily	With little difficulty	With moderate difficulty	With great difficulty	No, impossible
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

10. During the past 4 weeks...

Have you been able to wash and dry yourself under both arms?

Yes, easily	With little difficulty	With moderate difficulty	With extreme difficulty	No, impossible
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

11. During the past 4 weeks...

How much has pain from your shoulder interfered with your usual work (including housework)?

Not at all	A little bit	Moderately	Greatly	Totally
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

12. During the past 4 weeks...

Have you been troubled by pain from your shoulder in bed at night?

No nights	Only 1 or 2 nights	Some nights	Most nights	Every night
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Please double check that you have answered each question.
Thank you!**