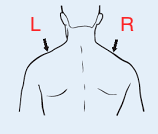
**SHOULDER EVALUATION**

**On this diagram mark where your pain is:**

****

**\*\*\*Weight: \_\_\_\_\_\_\_\_\_\_ Height: \_\_\_\_\_\_\_\_\_\_\*\*\***

For each, circle what **BEST** applies:

* The pain is: OCCASIONAL INTERMITTENT CONSTANT
* The pain is: DULL SHARP ACHY THROBBING BURNING STABBING

Circle **ALL** symptoms that apply:

CATCHING POPPING LOCKING GRINDING SWELLING STIFFNESS

INSTABILITY WEAKNESS TINGLING NUMBNESS NIGHT PAIN

When is your pain worse? Mornings: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Evenings: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Always: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is it worse after activity? Yes: \_\_\_\_\_\_\_\_\_\_\_\_ No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is your pain today on a scale of 1-10? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What tests have you had regarding this injury? None: \_\_\_ X-Rays: \_\_\_\_ MRI: \_\_\_\_ CT Scan: \_\_\_ EMG/NCV: \_\_\_

Have you had any treatment for this injury? None: \_\_\_ Medications: \_\_\_ Therapy: \_\_\_ (Duration \_\_\_\_\_\_\_\_\_\_)

Surgery: \_\_\_ Injections: \_\_\_ Pain Management: \_\_\_\_

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Was any of the treatment effective? Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Put an X in the box that indicates your ability to do the following activities:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Unable to do | Very Difficult | Somewhat Difficult | Not Difficult |
| Sleeping |  |  |  |  |
| Reaching |  |  |  |  |
| Lifting 10 lbs above shoulder |  |  |  |  |
| Doing usual work |  |  |  |  |

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Dr. Lawrence Lenderman or my insurance company to release any information required to process my claims.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SIGNATURE DATE