

PATIENT HISTORY QUESTIONNAIRE

SHOULDER

NAME: _____ AGE: _____ TODAY'S DATE: _____

DOMINATE HAND: RIGHT _____ LEFT _____

Which SHOULDER(S) is painful? _____ How long has it been painful? _____

Was there an injury to your SHOULDER(S)? _____ If yes, please describe: _____

Where is your pain located? (front, back, top, medial, lateral, etc.): _____

Describe your pain (dull, sharp, constant, aching, etc.): _____

What are some of your symptoms?

- | | | |
|-------------------------------|-------------------------------|---------------------------|
| _____ Swelling/Fluid | _____ Weakness | _____ Popping/Clicking |
| _____ Bruising | _____ Night Pain | _____ Locking |
| _____ Instability | _____ Numbness/Tingling | _____ Stiffness |
| _____ Limited Range of Motion | _____ Referred/Traveling Pain | _____ Buckling/Giving Out |

Pain Level: 1 2 3 4 5 6 7 8 9 10 (please circle)
Least Most

PREVIOUS TREATMENT:

1. Do you have any X-RAY's of your SHOULDER(S)? _____
If yes, when and where were they done & who was the ordering physician? _____
2. Do you have an MRI of your SHOULDER(S)? _____
If yes, when and at what facility did you have the MRI? _____
3. Are you taking medications specific to your SHOULDER pain? _____
If yes, which medication(s)? _____
4. Have you had previous treatment by another Doctor, any Physical Therapist, Acupuncturist, or Chiropractic treatment for your SHOULDER(S)? _____
If yes, by whom & when? _____
5. Have you had any surgery on your SHOULDER(S)? _____
If yes, by whom & when? _____
6. Is a legal case involved with this injury? _____ Is this a work related injury? _____

**IF YOU ANSWERED YES TO EITHER ONE OF THE QUESTIONS IN #6, PLEASE FILL OUT THE WORK RELATED INJURY FORM.
THANK YOU**