



### Shoulder History

Name: \_\_\_\_\_

Doctor: \_\_\_\_\_

Date: \_\_\_\_\_

Date of Birth/Age: \_\_\_\_\_

Chief Complaint:

Date of Onset or Injury: \_\_\_\_\_

Shoulder:

On the job injury? \_\_\_\_\_

Industrial \_\_\_\_\_

Pain:

Location

Type: (dull, sharp, etc.)

Brought on by

Tender to direct pressure?

Major activities which worsen pain:

Improving, stable or increasing?

Ways of obtaining relief?

Intensity:

Treatment thus far and helpfulness?

Weakness and in what activities?

Involvement in other areas of the body, (i.e. arm, neck) pain or stiffness?

Tingling, numbness or pain shooting down arm?

Past history of shoulder problems, injuries or surgeries?

Past history of bone or joint complaints?

Major medical illnesses?

Family history of bone or joint problems?

=anded?

Occupation:

Special sport or recreation activities which require use of shoulder?

FOR OFFICE USE ONLY

X-RAY REQUESTED:

\_\_\_\_\_  
PHYSICIAN SIGNATURE

Physical Exam:

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

**Extension/ Flexion/ Internal Rotation/ External Rotation/ Abduction/ Adduction**

Right / ...../ / ...../

Left / ...../ / ...../

Deformity: <30 degrees flexion contracture – 4

<10 degrees fixed adduction --- 4

<10 degrees fixed IR in ext --- 4

< 3.2 cm LLD ----- 4

Tenderness:

LLD:

Skin:

Motor:

Sensation:

Reflexes:

Pulses: DP .....PT

X-rays:

MRI:

Treatment Plan:

HHS: