OrthoTexas
Orthopedics & Sports Medicine

SHOULDER

Was this an injury or did it occur over time?_____

How long have you had this problem or what was the date of your injury?_____

Where specifically on your body do you have the problem?_____

If an injury, describe how it occurred:_____

Have you had this problem before? Yes / No

If yes, how was it treated?_____

Rate your pain: No Pain 1 2 3 4 5 6 7 8 9 10 Absolute Pain

Describe your pain (circle all that apply):

Sharp	Aching	Stabbing	Dull
Constant Burn	Come and go	Pins & needles	Electric
Explosive	Unrelenting	Throbbing	Other:_____
Constant	Intermittent	Chronic	_____
Getting better	Getting worse	Unchanged	
Worse in the morning	Worse in the evening	Worse at night	

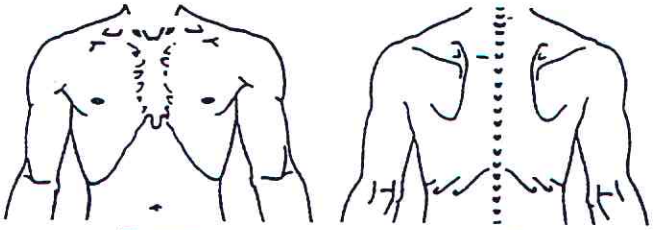
What makes your pain **worse**?_____

What makes your pain **better**?_____

Medications used for this problem:_____

Have you had any tests for this problem? MRI / Bone Scan / X-ray / Other_____

Please indicate the location of your pain with an X:



Front Back

Do you have numbness or tingling? Yes / No If yes, where?_____

Do you have swelling? Yes / No If yes, where?_____

Have you had instability or dislocations? Yes / No Do you have popping / catching / grinding?

Do you have neck pain? Yes / No Have you had any shoulder surgery? Yes / No

Do you have any other problems not previously described? Yes / No If yes, please describe:_____

_____

Referring Physician:_____

Other Physician(s) you have seen for this problem:_____

Date(s) of work/school missed for this problem:_____

Is there an attorney involved with this problem? Yes / No If yes, please provide additional information:_____

_____

Patient Name *(print)*:_____ Patient Signature:_____ Date:_____