ORTHOPEDIC ASSOCIATES, PA

SHOULDER HISTORY

Patient:_____ Date: _____

1. Why are you being seen today? _____
2. What were you doing at the time of the injury or onset of pain? _____

   _____
3. When did the pain occur? Immediately ☐Same Day ☐Few Days Later
   ☐That Night ☐Next Day ☐Gradual Onset
4. Type of Pain? ☐Sharp ☐Stabbing ☐Dull Aching ☐Burning
   How often does the pain occur? ☐Constant ☐intermittent ☐Occasional
5. Does the pain keep you awake at night? ☐Yes ☐No ☐Sometimes
6. Where is the pain located? ☐Shoulder ☐Neck ☐Arm ☐Elbow ☐Chest
   ☐Shoulder Blade ☐Hands / Fingers ☐Collar Bone
7. What, if anything, makes the pain better? _____
8. What, if anything, makes the pain worse? _____
9. When moving your shoulder do you have? ☐Popping ☐Snapping ☐Grinding ☐Clicking
10. Do you have weakness? ☐Yes ☐No
11. Do you have difficulty holding objects such as a cup? ☐Yes ☐No
12. Do you have limited motion in your shoulders? ☐Yes ☐No ☐Sometimes
13. What type of recreational sports do you participate in? ☐Tennis ☐Golf ☐Swimming
    ☐Other:_____
14. Have you had previous treatment for this problem? ☐Yes ☐No
    If yes, by whom?_____
15. Have you had prior injuries? ☐Yes ☐No What / When;_____
16. Are you taking any medications? ☐Yes ☐No If so, what?_____
17. Past Medical History?

What	Date
_____	_____
_____	_____
_____	_____
_____	_____