Umhlanga Ridge Orthopaedic Centre

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# SHOULDER QUESTIONAIRE

NAME: _____

Handedness Left ☐ Right ☐

Which shoulder is troubling you Left ☐ Right ☐ Both ☐

How long has the shoulder troubled you? _____

Do you recall what caused the problem? _____

**PLEASE TICK ALL THE BOXES APPLICABLE TO YOUR SHOULDER PAIN**

Dull ☐ Aching ☐ Sharp ☐

Constant ☐ Intermitent ☐

Pain when moving your arm: ☐

- Above the level of your shoulder ☐
- Reaching behind your back ☐

Pain mostly at night ☐

Pain travels down your arm ☐

Neck pain ☐

Pins and needles ☐

Weakness ☐

Loss of motion ☐

Can you lift your arm above your head? Yes ☐ No ☐

Does your shoulder ever feel:

- Loose ☐
- Slip in/out of its socket ☐
- Get stuck or lock ☐
- Catch, pop or click ☐

Has your shoulder ever dislocated? Yes ☐ No ☐

How bad is the pain? (1 meaning minimal and 10 being extreme pain) _____

Have you had previous surgery to your shoulder? Yes ☐ No ☐

Does your job involve repititive arm/shoulder movement? Please describe

_____

Do you exercise or play sport? Please describe

_____