

	PENINSULA ORTHOPAEDIC ASSOCIATES New Patient/New Problem SHOULDER	Name:	
		POA ID#:	
		Date:	
		Birth Date:	Age:
		Primary Care Physician:	

What is the name of the medical provider who sent you here today? _____

	RIGHT SHOULDER	LEFT SHOULDER
My dominant hand?	<input type="checkbox"/> Right	<input type="checkbox"/> Left
Which shoulder hurts?	<input type="checkbox"/> Right only <input type="checkbox"/> Left only <input type="checkbox"/> R=L <input type="checkbox"/> R more than L <input type="checkbox"/> L more than R	
When did the problem start?		
Did you have an injury?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, what injury did you have?		
What does the pain feel like?	<input type="checkbox"/> Dull <input type="checkbox"/> Sharp <input type="checkbox"/> Burning	<input type="checkbox"/> Dull <input type="checkbox"/> Sharp <input type="checkbox"/> Burning
Is the pain?	<input type="checkbox"/> Constant <input type="checkbox"/> Intermittent	<input type="checkbox"/> Constant <input type="checkbox"/> Intermittent
What makes it worse?	<input type="checkbox"/> Movement <input type="checkbox"/> Keeping Still	<input type="checkbox"/> Movement <input type="checkbox"/> Keeping Still
How bad is the Pain	None 0 1 2 3 4 5 6 7 8 9 10 Worst Possible	None 0 1 2 3 4 5 6 7 8 9 10 Worst Possible
Where is the pain?	<input type="checkbox"/> Front <input type="checkbox"/> Top <input type="checkbox"/> Outer side <input type="checkbox"/> Back	<input type="checkbox"/> Front <input type="checkbox"/> Top <input type="checkbox"/> Outer side <input type="checkbox"/> Back
Which causes shoulder pain?	<input type="checkbox"/> Shoulder movement <input type="checkbox"/> Neck movement	<input type="checkbox"/> Shoulder movement <input type="checkbox"/> Neck movement
Do you have pain at night?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Occasionally	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Occasionally
Has your shoulder dislocated? If yes, how many times?	<input type="checkbox"/> Yes <input type="checkbox"/> No _____	<input type="checkbox"/> Yes <input type="checkbox"/> No _____
Does your shoulder feel unstable?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
What treatment have you tried?	____ None ____ Medications ____ Injections How many__ ____ Physical Therapy ____ Surgery	____ None ____ Medications ____ Injections How many__ ____ Physical Therapy ____ Surgery
How was your shoulder prior to this episode of pain?	____ Normal ____ Abnormal	____ Normal ____ Abnormal
Did you hurt yourself at work?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you involved in litigation?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have pain in your neck?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<i>For workers' compensation and litigation patients only</i>		
	RIGHT	LEFT
Did you have pain before the injury at work?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, when did it start?		
How bad was the pain prior to the work /litigation injury?	None 0 1 2 3 4 5 6 7 8 9 10 Worst Possible	None 0 1 2 3 4 5 6 7 8 9 10 Worst Possible
How long after the work /litigation injury did the pain start?		