Shoulder Intake Survey
Brian J. Cole, MD, MBA

Last Name _____ First Name _____ Today's Date ___ /___ /____

Email Address _____

Information regarding your current shoulder problem: When did your shoulder problem begin? __/__/__

Is your problem to the: Right shoulder _____ Left shoulder _____ Both shoulders _____

Work related injury? Yes_____ No_____ If YES, date injury reported ___ /___ /____

Please describe your shoulder problem:

1. Problem with your shoulder _____
2. Was this a result of an injury? Yes_____ No _____ Was it: Gradual_____ Sudden_____
   If YES , describe what happened: _____
   _____
3. Does your shoulder feel unstable? Yes_____ No _____
4. Does your shoulder allow you to sleep at night? Yes_____ No_____
5. Is your shoulder problem getting: Worse_____ Better_____ Staying the same _____
6. Date and results if known of imaging studies performed for your shoulder:
   a. Xrays: _____ c. CT scan: _____ e. Other_____
   b. MRI: _____ d. EMG: _____
7. Have you had any of the following non-operative treatment to date:
   a. Physical Therapy: Yes _____ No _____
      If YES, duration and response to PT:_____
   b. Non-steroidal anti-inflammatoies (NSAIDS): Yes_____ No_____
      If YES, name of NSAID and response to NSAID:_____
   c. Cortisone injections: Yes_____ No_____
      If YES, date(s) and response to cortisone injections: _____
8. Have you had any surgical procedures on the shoulder?: Yes_____ No _____
   If YES, please provide dates, procedure description and surgeon name.

   i. Date: ___/___/___ Procedure: _____ MD Name: _____
   ii. Date: ___/___/___ Procedure: _____ MD Name: _____
   iii. Date: ___/___/___ Procedure: _____ MD Name:_____
   iv. Date: ___/___/___ Procedure: _____ MD Name:_____

Pain and Function questions

Do you currently have pain in your shoulder? Yes _____ No _____

If YES, please list the average intensity of pain on scale of 0-10 over the last 7 days (0=Normal and 10 = severe pain) _____

How often do you experience pain in your shoulder? Never _____ Intermittent _____ Constant _____

Is there anything that helps to alleviate your shoulder pain? _____

Do you ever take pain medication for your shoulder pain? Yes_____ No_____

If YES, please list:

1. _____ 2. _____ 3. _____

4. _____ 5. _____

	YES	NO
Is your shoulder comfortable at your side?		
Can you reach the small of your back to tuck in your shirt?		
Can you place your hand behind your head?		
Can you place a coin on a shelf at shoulder level without bending your elbow?		
Can you lift one pound to the level of your shoulder without bending the elbow?		
Can you carry 20 lbs at your side with your affected arm?		
Can you toss a ball underhand 10 yards with your affected arm?		
Can you throw a ball overhand 20 yards with your affected arm?		
Would your shoulder allow you to work full time at your usual job?		

Please list any additional information that you feel would be important for us to know regarding the condition of your shoulder including what your specific goals and expectations are related to your treatment outcomes:

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