BRISBANE KNEE & SPORTS SURGERY

SHOULDER QUESTIONNAIRE

Name: **Date:**

Age: **Birth Date:** **Are you Right or Left handed**

Is this Workcover: Y N **What is your job description:**

What is the problem with your shoulder?

Is the current problem a result of :

Car Accident		If Other please specify:
Work injury		
Sports Injury		
Other		

HISTORY

Which shoulder is the problem? R L Both

When did the problem start?

Have you had previous problems with your shoulder?

What problems are you experiencing? Please tick all that apply

Pain		
Stiffness		
Catching/locking		
Weakness		
Swelling		
Limited Motion		
Instability / dislocation		
Grinding / popping		
Clicking		

What makes the problem better?

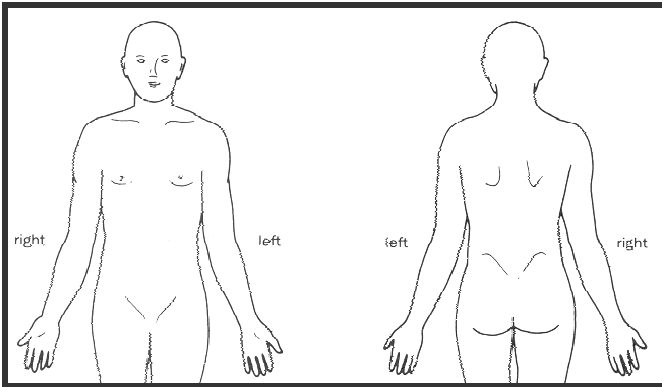
What makes the problem worse?

PAIN

Quality of pain:

Throbbing		
Sharp		
Dull		
Aching		
Stabbing		
Burning		

Location of pain: Please mark location on diagram.



How severe is your pain? Please mark on the score below

NO PAIN 0_1_2_3_4_5_6_7_8_9_ 10 SEVERE PAIN

Frequency of pain:		
Rarely		
Occasionally		
Frequently		
Constantly		
When does the pain occur?		
Morning		
Day		
Evening		
Night		
Interrupts sleep, if so how many times?		
Weather change		
When is the pain made worse?		
Resting		
At work		
Throwing		
Any shoulder movement		
Driving		
Sleeping on shoulder		
Reaching above head		
Reaching away from you		
Reaching behind you		
Lifting		
Other		
When is the pain relieved?		
Nothing		
Rest		
Activity		
Medication		
Injection		
Physiotherapy		
Ice		
Heat		

INSTABILITY

If your shoulder does not " go out of place", skip this section

My shoulder is/was unstable:		
At the time of original injury		
With simple movement		
Partially goes back in		
Regularly		
With major movement		
Never but feels like it might		
How often does your shoulder feel insecure?		

How often does your shoulder dislocate?

Date of first dislocation:
Please describe the events surrounding your first dislocation?

Date of last dislocation:

Does your shoulder hurt when it is out of place?

Are you intentionally able to slip your shoulder out of place?

Have you required help to put your shoulder back in, if so by whom?

Your shoulder goes back in:

Easily	
Moderately	
With great difficulty	

Describe your shoulder position when it goes out?

Where does your shoulder go out?

Front	
Back	
Armpit	
Not sure	

How unstable is your shoulder? Please mark on the score below

VERY STABLE 0 --- 10 VERY UNSTABLE

ACTIVITIES

Do you have difficulty with the following activities:

Activity	Right Arm	Left Arm
Washing hair	**Y N**	**Y N**
Combing hair	**Y N**	**Y N**
Washing back / do up bra	**Y N**	**Y N**
Lying on shoulder	**Y N**	**Y N**
Getting dressed	**Y N**	**Y N**
Reach a high shelf	**Y N**	**Y N**
Do your usual work	**Y N**	**Y N**
Sports / hobbies	**Y N**	**Y N**

PRIOR TREATMENT FOR THIS PROBLEM

Have you seen a specialist for this problem Y N if yes, whom:

What was the diagnosis?

What was their treatment?

Type of treatment	Type	How often	Period of time	Help Hurt No effect
Analgesics				
Anti-inflammatories				
Cortisone injections				
Rest				
Chiropractic				
Massage therapy				
Acupuncture				

Physiotherapy treatment? Y N if yes, please detail below.

Day / Month / Year	Physiotherapist	Type of Physio	Results

Previous shoulder surgery? Y N if yes, please detail below.

Month/Day/Year	Surgeon	Type of surgery	Results

X – RAYS / SCANS

X – rays / ultrasound: Y N If yes, please complete below

Day/ Month / Year

Previous MRI /CT scan : Y N If yes, please complete below

Month / Day / Year	Location	Type of scan	Results

MEDICAL HISTORY

Please circle

Do you suffer from neck pain?	N	Y
Do you have pins & needles / altered sensations in your arms?	N	Y
Do / did you have any heart problems?	N	Y
Do / did you have ulcers / gastritis?	N	Y
Do / did you have diabetes?	N	Y
Do / did you have liver problems / hepatitis?	N	Y
Do / did you have kidney disease?	N	Y
Do / did you have cancer?	N	Y
Do /did you have blood clots?	N	Y
Do /did you smoke cigarettes? (if yes, how many)	N	Y
Do / did you drink alcohol? (if yes, how many units per week)	N	Y
Do you suffer from any allergies?	N	Y

Please use the space below to explain any of the above