QUESTIONNAIRE FOR NEW SHOULDER PATIENTS

JAMES R. DEMARCO, MD

NAME: ______________________________ DATE: ______________

Patient ID#: ______________ AGE: __________ Occupation: ______________

Are you right handed or left handed? (circle one) RIGHT LEFT

Date of onset of pain or injury (Give a specific date, if possible) ______________

Describe in detail the nature of the injury ______________

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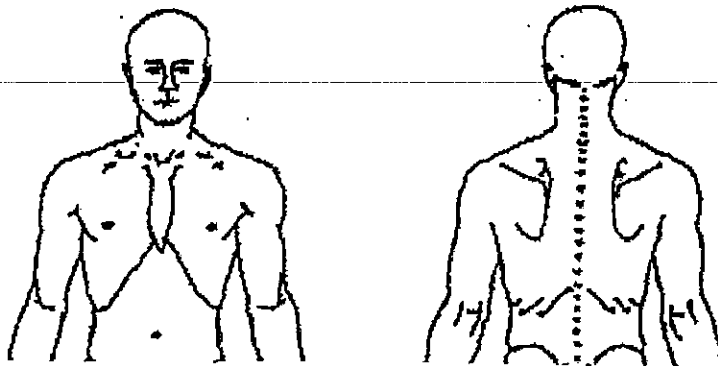
Using these symbols, mark the area on your body where you feel the described sensations.

ACHING ΔΔΔΔΔ **NUMBNESS** ==== **PINS & NEEDLES** 0 0 0 0 **BURNING** XXX **OTHER** ▪▪▪



Rate your pain on the scale: (circle one) **Lowest** 1 2 3 4 5 6 7 8 9 10 **Highest**

What makes the pain worse? ______________

What makes the pain better? ______________

Do you have pain at night? Describe it: ______________

Do you have neck pain? (circle one) YES NO Numbness or tingling in your arms? (circle one) YES NO

Have you had any previous injuries to your shoulder, neck or elbow on this side? (circle one) YES NO
If yes, describe: ______________

Have you previously had physical therapy for this particular problem? (circle one) YES NO
If yes, when and where was the therapy give? ______________

Have you previously had injections for this problem? (circle one) YES NO
If yes, when and did the injection help? ______________

What medications do you take for pain? (List all over-the-counter and prescription medications)

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What is the most active thing you do with your arms, i.e. sports, chores, home repair or work related activity?

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