



HEIDEN ORTHOPAEDICS

INITIAL SHOULDER PATIENT EVALUATION FORM

NAME:

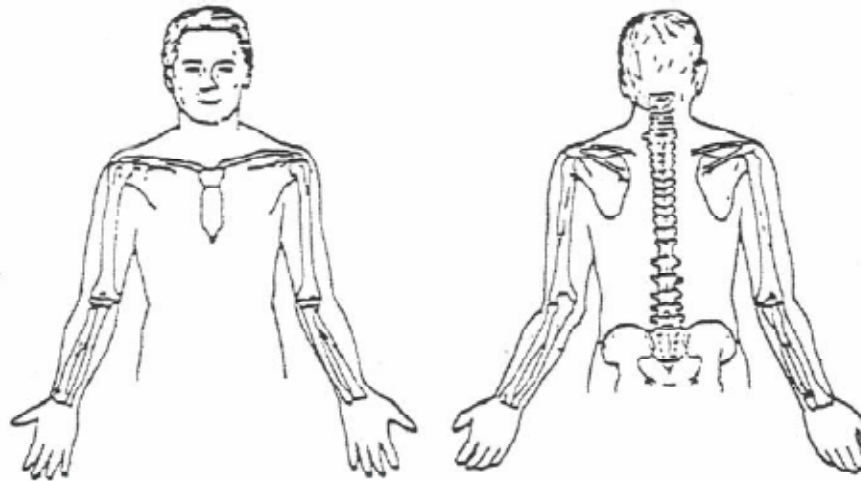
DATE:

AGE: HAND DOMINANCE: R L Ambidextrous SEX: M F

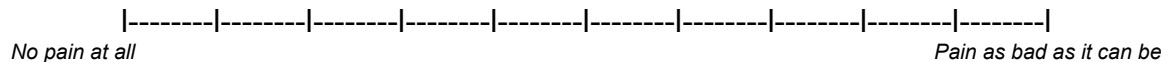
IS YOUR VISIT TODAY DUE TO AN INJURY? Y N

IF YES, DATE OF INJURY?

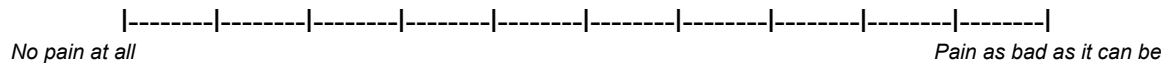
Mark the area(s) where you are having pain in the illustration(s) below:



How bad is your pain at rest? (**mark on line below**):



How bad is your pain with activity? (**mark on line below**):



Do you feel joint instability? (as if it is slipping or coming out of place)? Y N

If so, which joint? _____

INSTRUCTIONS: This questionnaire asks about your symptoms as well as your ability to perform certain activities.

Please answer **every question**, based on your condition in the last week.

If you did not have the opportunity to perform an activity in the past week, please make your **best estimate** of which response would be the most accurate.

It doesn't matter which hand or arm you use to perform the activity; please answer based on your ability regardless of how you perform the task.

Please rate your ability to do the following activities in the last week by placing a check mark next to the number for the appropriate response.

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	UNABLE TO PERFORM
1. Open a tight or new jar.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
2. Do heavy household chores (e.g., wash walls, floors).	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
3. Carry a shopping bag or briefcase.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
4. Wash your back.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
5. Use a knife to cut food.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
6. Recreational activities in which you take some force or impact through your arm, shoulder, or hand (e.g., golf, hammering, tennis, etc.)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>

NOT AT ALL	SLIGHTLY	MODERATELY	QUITE A BIT	EXTREMELY
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Please rate your ability to do the following activities in the last week by placing a check mark next to the number for the appropriate response.

7. During the past week, to what extent has your arm, shoulder or hand problem interfered with your normal social activities with family, friends, neighbors or groups?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
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NOT LIMITED AT ALL	SLIGHTLY LIMITED	MODERATELY LIMITED	VERY LIMITED	UNABLE TO DO
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Please rate your ability to do the following activities in the last week by placing a check mark next to the number for the appropriate response.

8. During the past week, were you limited in your work or other regular daily activities as a result of your arm, shoulder or hand problem?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
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NONE	MILD	MODERATE	SEVERE	EXTREME
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Please rate the severity of the following symptoms in the last week by placing a check mark next to the number for the appropriate response.

9. Arm, shoulder or hand pain. 1 2 3 4 5
10. Tingling (pins and needles) in your arm, shoulder or hand. 1 2 3 4 5

NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	SO MUCH DIFFICULTY THAT I CAN'T SLEEP
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Please rate the severity of the following symptoms in the last week by placing a check mark next to the number for the appropriate response.

11. During the past week, how much difficulty have you had sleeping because of the pain in your arm, shoulder or hand? 1 2 3 4 5

WORK MODULE (OPTIONAL)

The following questions ask about the impact of your arm, shoulder or hand problem on your ability to work (including homemaking if that is your main work role).

Please indicate what your job/work is:

I do not work. (You may skip this section.)

Please place a check mark next to the number that best describes your physical ability in the past week.

NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	UNABLE
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Did you have any difficulty:

1. using your usual technique for your work? 1 2 3 4 5
2. doing your usual work because of arm, shoulder or hand pain? 1 2 3 4 5
3. doing your work as well as you would like? 1 2 3 4 5
4. spending your usual amount of time doing your work? 1 2 3 4 5

SPORTS/PERFORMING ARTS MODULE (OPTIONAL)

The following questions ask about the impact of your arm, shoulder or hand problem on playing your musical instrument or sport, or both. If you play more than one sport or instrument (or play both), please answer with respect to that activity which is most important to you.

Please indicate the sport or instrument which is most important to you:

I do not play a sport or an instrument. (You may skip this section.)

Please place a check mark next to the number that best describes your physical ability in the past week.

NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	UNABLE
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Did you have any difficulty:

1. using your usual technique for playing your instrument or sport?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
2. playing your musical instrument or sport because of arm, shoulder or hand pain?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
3. playing your musical instrument or sport as well as you would like?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
4. spending your usual amount of time practicing or playing your instrument or sport?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>