



Before this shoulder problem started, were you having any problems with your shoulder?

yes

no

### **Painful Activities**

I have recently injured my shoulder and have severe pain that prevents me from using it.

I have **shoulder** pain with the following activities. Please check all that apply.

- using an ATM machine
- getting a parking ticket
- reaching in the back seat of the car
- putting on the seatbelt
- washing a car
- turning the steering wheel
- adjusting car mirror or radio
  
- performing gardening/yard work
- performing housework
- vacuuming
- pulling up bed covers
- sleeping
- doing the laundry
- starting a lawnmower
  
- putting a belt through the belt loops
- reaching my wallet
- fastening a bra
- Buttoning pants
- putting on a coat/shirt/sweater
- combing hair
- blow drying hair
  
- Lifting
- pushing / pulling
- Knitting/crochet
- doing computer work/typing
- pouring from pitcher
- getting milk from the refrigerator
- reaching overhead
- reaching out to the side
- carrying heavy objects

## SPORTS

Do you have **shoulder** pain with any of the following sports?  
Please check all that apply.

- |                                   |   |
|-----------------------------------|---|
| <input type="checkbox"/> golf     | <input type="checkbox"/> hockey         |
| <input type="checkbox"/> tennis   | <input type="checkbox"/> racquetball    |
| <input type="checkbox"/> swimming | <input type="checkbox"/> basketball     |
| <input type="checkbox"/> bowling  | <input type="checkbox"/> weight lifting |
| <input type="checkbox"/> softball | <input type="checkbox"/> volleyball     |
| <input type="checkbox"/> baseball |   |

## How has your shoulder been treated up to now?

### I have

- NOT changed my work to adjust for my shoulder
- changed my work to adjust for my shoulder
- stopped working to adjust for my shoulder

what kind of work? \_\_\_\_\_

### For my shoulder problem I have already seen

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> my regular doctor | <input type="checkbox"/> a chiropractor       | <input type="checkbox"/> an orthopedic surgeon |
| <input type="checkbox"/> a neurosurgeon    | <input type="checkbox"/> a physical therapist | <input type="checkbox"/> a massage therapist   |
- 

Your general health and medications can affect your treatment. Please help us by providing the following information

**Do you have a Family Physician or Internist??**     Yes     No

Doctor: \_\_\_\_\_

Date of last visit \_\_\_\_\_      Date of last complete examination \_\_\_\_\_

**Would you like us to send a copy of our report to the doctor you listed above??**

Yes     No

Another doctor? \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

**MEDICATION**

- I have **not** taken any medication for my shoulder condition
- I **was** treated with medication

Name of medication \_\_\_\_\_

**INJECTIONS**

- I have **not** received an injection for my shoulder condition
- I **have** received an injection

**THERAPY**

- I have **not** had any therapy for my shoulder condition
- I **have** received therapy for my shoulder condition

Date therapy started and duration: \_\_\_\_\_

**SURGERY**

- I have **not** had any surgery for my shoulder condition
- I **have** had any surgery for my shoulder condition

Date and type of surgery: \_\_\_\_\_

**Family History:** Please provide any pertinent family medical history relating to your parents

| Illness/condition | Father | Mother | Age at diagnosis | Living?<br>If no, date of death |
|-------------------|--------|--------|------------------|---------------------------------|
|                   |        |        |                  |                                 |
|                   |        |        |                  |                                 |
|                   |        |        |                  |                                 |
|                   |        |        |                  |                                 |
|                   |        |        |                  |                                 |
|                   |        |        |                  |                                 |
|                   |        |        |                  |                                 |

Unknown

## Medical problems (Review of Systems)

### ROS Heart

- No heart problems
- Heart attack
- Blocked arteries in the heart
- Congestive heart failure
- Palpitations
- murmur
- Cardiomyopathy
- Pericarditis
- Cardiomegaly
- Aortic aneurysm
- A-fib
- Conduction disorder
- Atrial flutter
- Mitral insufficiency
- hypertensive heart disease
- Angina
- Mitral Valve Prolapse
- Rheumatic heart disease
- Cardiac pacemaker

### ROS Vascular

- No vascular problems
- Anemia
- Hypotension (low blood pressure)
- Fainting
- Hypertension (high blood pressure)
- Phlebitis
- varicose veins
- Vasovagal
- Venous insufficiency

### ROS Lungs

- No lung problems
- Asbestosis
- asthma
- bronchitis
- COPD
- emphysema
- PE (pulmonary embolism)
- pneumonia
- pneumothorax
- shortness of breath
- Sleep apnea

### ROS Gastrointestinal

- No GI problems
- Achalasia
- anorexia
- c diff
- colitis
- chron's
- diverticulitis
- ulcer
- reflux
- fecal incontinence
- gastric bypass
- gastritis
- hiatal hernia
- Irritable bowel syndrome
- pancreatitis

### ROS Hepatitis

- Hepatitis A (year\_\_\_\_\_)
- Hepatitis B (year\_\_\_\_\_)
- Hepatitis C (year\_\_\_\_\_)
- Hepatitis type unknown
- acute
- chronic
- past resolved

### ROS Genitourinary

- No GU problems
- Acute renal failure
- Chronic renal failure
- cystitis
- dialysis
- kidney stones
- urinary incontinence

### ROS Neurologic

- No neurological problems
- Alzheimers
- Carpal tunnel syndrome
- Cerebral Palsy
- Dementia
- Diabetic neuropathy
- Epilepsy

### ROS Psychological

- No psychological problems
- Alcoholism
- Anxiety
- Bipolar disorder
- Depression
- Drug dependence
- Eating disorder
- Insomnia
- Obsessive compulsive disorder
- Panic attacks
- Phobias
- Schizophrenia

- Paraplegia
- Parkinson's
- Peripheral neuropathy
- Migraines
- Polio
- Seizures
- Stroke
- TIA's

### ROS Endocrine

- No Endocrine problems
- Diabetes non insulin dependent
- Diabetes insulin dependent
- Graves
- Addison's
- Gout
- Hypothyroidism

### ROS Infection

- No infectious disease problems
- HIV
- AIDS
- TB
- MRSA

### ROS ENT (Ear, Nose and Throat)

- No HEENT problems
- Dystonia
- Hearing Aid
- Hearing Loss
- Sinusitis
- Vertigo (positional)

### ROS Eyes

- No eye problems
- Blindness
- Cataracts
- Glaucoma
- Macular degeneration
- Retinopathy

### ROS Skin

- No skin problems
- Cellulitis
- Eczema
- Psoriasis
- Rosacea
- Shingles

### ROS Breast

- No breast problems
- Benign Mass
- Cyst
- Fibrocystic Disease
- Mastitis
- Breast Cancer

**Do you have any allergies??**

To medicines     NO     YES    Describe: \_\_\_\_\_

Metal Allergy:     NO     YES    Type of Metal: \_\_\_\_\_

To iodine             x-ray dye             shellfish             latex

**Pharmacy Name**(and address if known): \_\_\_\_\_

**Pharmacy Phone #:** \_\_\_\_\_

**Please list the medications you are currently taking**

I am **not** currently taking any medication

I am taking the following medication.

| Medication | Dosage | times/day |
|------------|--------|-----------|
| 1. _____   |        |           |
| 2. _____   |        |           |
| 3. _____   |        |           |
| 4. _____   |        |           |

**Social History**

The amount you drink and smoke can affect how well bones and ligaments heal and how you react to medicines or anesthesia.

**Alcohol**

I do not drink

I am a social drinker

I am a daily drinker

\_\_\_\_\_ Beers / day

\_\_\_\_\_ Beers / week

\_\_\_\_\_ Glasses of wine / day

\_\_\_\_\_ Glasses of wine / week

\_\_\_\_\_ Liquor drinks / day

\_\_\_\_\_ Liquor drinks / week

**Tobacco**

I do not smoke

I smoked but stopped

\_\_\_\_\_ year stopped smoking

I smoke

\_\_\_\_\_ packs per day for

\_\_\_\_\_ number of years

\_\_\_\_\_ cigars / week

I chew tobacco