Patient Self Assessment For Shoulders

Patient Name: ______________________________ **Date:** ______________________

INSTRUCTIONS:

This survey asks for your views about your shoulder. If you are unsure about how you should answer a question please give the best answer you can. Please do not make any marks on the pages other than in the ovals.

Shoulder to be evaluated: (fill in the correct oval) Right ⬭ Left ⬭

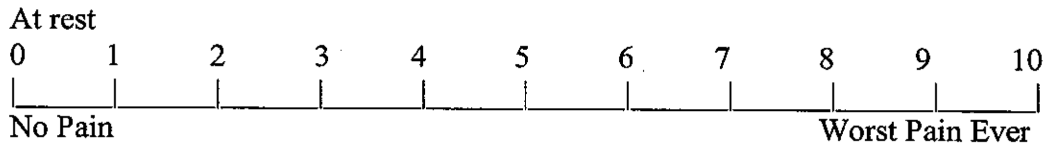
	YES	NO
1. Is your shoulder comfortable with your arm at rest by your side?	⬭	⬭
2. Does your shoulder allow you to sleep comfortably?	⬭	⬭
3. Can you reach the small of your back to tuck in your shirt with your hand?	⬭	⬭
4. Can you place your hand behind your head with the elbow straight out to the side?	⬭	⬭
5. Can you place a coin on a shelf level with your shoulder without Bending your elbow?	⬭	⬭
6. Can you lift one pound (a full pint container) level with your shoulder without bending your elbow?	⬭	⬭
7. Can you lift eight pounds (a full gallon container) level with your shoulder without bending your elbow?	⬭	⬭
8. Can you carry twenty pounds at your side with the affected extremity?	⬭	⬭
9. Do you think you can toss a softball overhand twenty yards with the affected extremity?	⬭	⬭
10. Do you think you can toss a softball underhand twenty yards with the affected extremity?	⬭	⬭
11. Can you wash the back of your opposite shoulder with the affected extremity?	⬭	⬭
12. Would your shoulder allow you to work full-time at your regular job?	⬭	⬭

Patient Self Assessment

Patient Name:	Date:

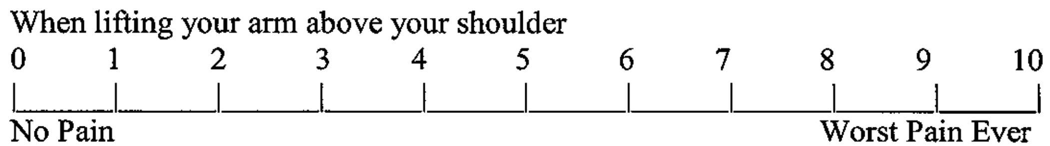
1. Shoulder: Right________ Left________
2. Please rate your pain (make mark on the scale)

At rest

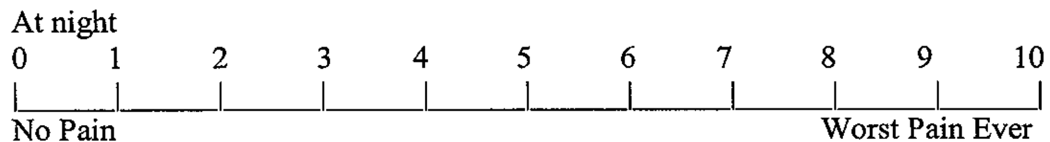


Lifting Heavy Objects

When lifting your arm above your shoulder



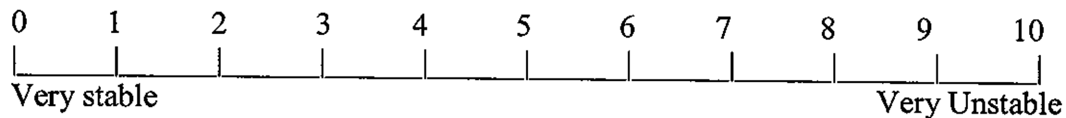
At night



Patient Self Assessment

Patient Name:	Date:

1. Does your shoulder feel unstable (as if it is going to dislocate?) Yes / No
2. How unstable is your shoulder (mark line)?



3. If your shoulder feels unstable, mark one section that best defines your shoulder

◯	◯	◯	◯
<u>No Limitation</u> in overhead activities; performs all work and sports; shoulder strong in swimming, tennis, throwing; no discomfort.	<u>Mild Limitation</u> in work and sports; shoulder strong; minimum discomfort.	<u>Moderate Limitation</u> in overhead work and heavy lifting; unable to throw, serve hard in tennis, or swim; moderate disabling pain.	<u>Marked Limitation</u> and unable to perform overhead work and lifting; cannot throw, play tennis, or swim; chronic discomfort.

4. Circle the number that indicates your ability to do the following activities:
   (0=unable to do, 1=very difficult, 2=somewhat difficult, 3=not difficult)

Activity	Right Arm	Left Arm
1. Put on a coat	0 1 2 3	0 1 2 3
2. Sleep on your painful or affected side	0 1 2 3	0 1 2 3
3. Wash back/Do up bra in back	0 1 2 3	0 1 2 3
4. Managing toileting	0 1 2 3	0 1 2 3
5. Comb hair	0 1 2 3	0 1 2 3
6. Reach a high shelf	0 1 2 3	0 1 2 3
7. Lift 10 pounds above shoulder	0 1 2 3	0 1 2 3
8. Throw a ball overhand	0 1 2 3	0 1 2 3
9. Do usual work – list:	0 1 2 3	0 1 2 3
10. Do usual sport – list:	0 1 2 3	0 1 2 3