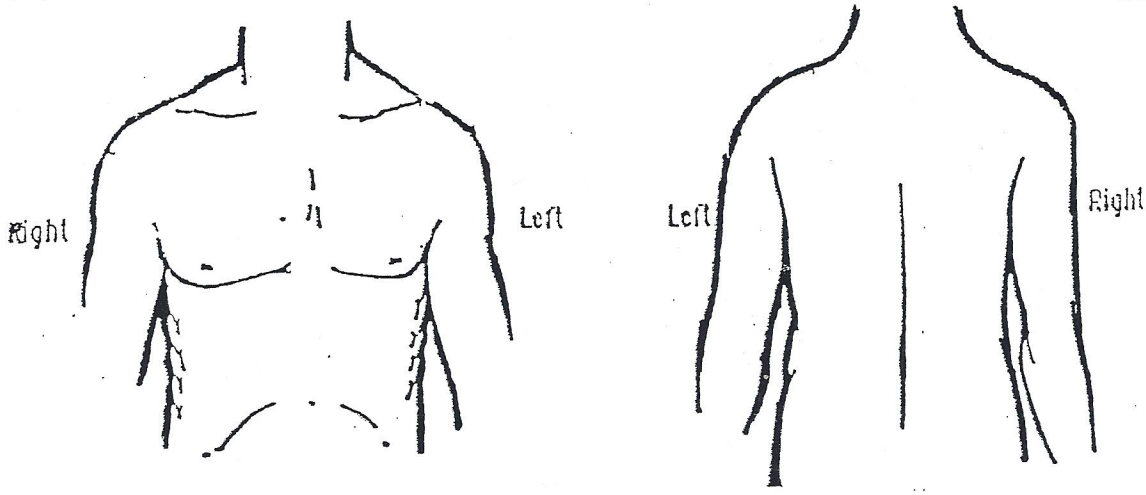
Patient # _____

Date _____

Shoulder



Please circle on the above drawing where you are having pain or symptoms.

Describe the sensations or symptoms you are experiencing (pain, aching, tingling, burning, numbness, etc.)

_____

Is this a result of an injury? **YES** ____ **NO** ____ If YES, give the date? _____(month-day-year)

If YES, explain how and where your injury occurred:_____

_____

Is this work related? **YES** ____**NO** ____

If this was not an injury, how long have you been experiencing your symptoms? _____

Which shoulder will we be examining? **Left** ____ **Right** ____

Is the range of motion in *this* shoulder limited? **YES** ____ **NO** ____ In which direction? _____

Is your shoulder unstable? **YES** ____ **NO** ____ In which direction? _____

Has your shoulder ever been dislocated? **YES** ____ **NO** ____

Have you ever had surgery on this shoulder before? **YES** or **NO** (circle) If YES, when, where, and what has the surgery done for you?

Have you ever had x-rays, a CT scan, or MRI scan for *this* problem? **YES** ____**NO** ____ If YES, when and where, and what did they show? _____

What has your doctor told you about your problem?_____

_____

Do you have a history of cancer? **YES** ____ **NO** ____ If YES, what type? _____

Are you currently being treated? _____

Please give us your **HEIGHT** _____ **WEIGHT** _____