Name: _____ DOB: _____

Shoulder Pain and Disability Index

Pain Scale

How severe is your pain?
Select the number that best describes the pain where 0 = no pain and 10 = the worst pain imaginable.

At its worst?

0 1 2 3 4 5 6 7 8 9 10

When laying on the involved side?

0 1 2 3 4 5 6 7 8 9 10

Reaching for something on a high shelf?

0 1 2 3 4 5 6 7 8 9 10

Touching the back of your neck?

0 1 2 3 4 5 6 7 8 9 10

Pushing with involved arm?

0 1 2 3 4 5 6 7 8 9 10

Disability Scale

How much difficulty do you have?
Select the number that best describes your experience where 0 = no difficulty and 10 = so difficult it requires help.

Washing your hair?

0 1 2 3 4 5 6 7 8 9 10

Washing your back?

0 1 2 3 4 5 6 7 8 9 10

Putting on an undershirt or sweatshirt?

0 1 2 3 4 5 6 7 8 9 10

Putting on a shirt that buttons down the front?

0 1 2 3 4 5 6 7 8 9 10

Putting on your pants?

0 1 2 3 4 5 6 7 8 9 10

Placing an object on a high shelf?

0 1 2 3 4 5 6 7 8 9 10

Carrying a heavy object on a high shelf?

0 1 2 3 4 5 6 7 8 9 10

Carrying a heavy object of 10 pounds?

0 1 2 3 4 5 6 7 8 9 10

Removing something from your back pocket?

0 1 2 3 4 5 6 7 8 9 10