University Hospitals
Case Medical Center

Michael J. Salata, MD
Assistant Professor of Orthopaedic Surgery
Division of Sports Medicine

Shoulder Survey

Name: _____ Date: ___/___/___ Date of Birth: ___/___/___
Last First MI

Gender: ☐ Male ☐ Female Dominant Hand: ☐ Right ☐ Left Problem Shoulder: ☐ Right ☐ Left Job Injury: ☐ Yes ☐ No

Occupation: _____ Date last worked: ___/___/___ Legal Claim: ☐ Yes ☐ No

How bad is you pain **today**?

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
0 1 2 3 4 5 6 7 8 9 10
No pain at all Worst pain imaginable

Which word below best describes your pain?

☐ None ☐ Moderate
☐ Mild ☐ Severe

Please select the statement that best describes your shoulder:

☐ I have no pain
☐ I have slight pain during activity
☐ I have increased pain during activities
☐ I have moderate/severe pain with activity
☐ I have severe pain and need medication

Yes	No	
☐	☐	Is your shoulder comfortable with your arm at rest by your side?
☐	☐	Does your shoulder allow you to sleep comfortably?
☐	☐	Can you reach the small of your back to tuck in your shirt?
☐	☐	Can you place your hand behind your head with the elbow straight out to the side?
☐	☐	Can you place a coin on a shelf at the level of your shoulder without bending your elbow?
☐	☐	Can you lift one pound (a full pint container) to the level of your shoulder without bending your elbow?
☐	☐	Can you lift 8 lbs. (a full gallon container) to the level of your shoulder without bending your elbow?
☐	☐	Can you carry 20 lbs. at your side with your affected arm?
☐	☐	Can you toss a ball underhand 10 yards with your affected arm?
☐	☐	Can you throw a ball overhand 20 yards with your affected arm?
☐	☐	Can you wash the back of your opposite shoulder with your affected arm?
☐	☐	Would your shoulder allow you to work full time at your usual job?

0=unable to do 1=very dificult to do
2=somewhat difficult 3=not diffucult

	Right arm	Left arm
Put on a coat	0 1 2 3	0 1 2 3
Sleep on your affected side	0 1 2 3	0 1 2 3
Wash back/connect bra in back	0 1 2 3	0 1 2 3
Manage toileting	0 1 2 3	0 1 2 3
Comb hair	0 1 2 3	0 1 2 3
Reach a high shelf	0 1 2 3	0 1 2 3
Lift 10 lbs. above shoulder	0 1 2 3	0 1 2 3
Throw a ball overhand	0 1 2 3	0 1 2 3
Do usual work-describe: _____	0 1 2 3	0 1 2 3
Do usual sport-describe: _____	0 1 2 3	0 1 2 3

Please select the <u>ONE</u> statement that best describes your injured shoulder's function.

☐ **Normal function.** I can do all activities of daily living, work and sports activities that I did before my injury (lifting 30 or more pounds, throwing, tennis, swimming).
☐ I have **mild limitations** in sports and work. I can throw but limited, can lift 15-20 pounds, able to wash back, comb hair and get dressed.
☐ I have **moderate limitations** in overhead work, sports and lifting (10 pounds). Unable to throw or serve in tennis. Have difficulty with washing back, combing hair or getting dressed (need help sometimes).
☐ I have **severe limitations**. Cannot do usual work or lifting. No sports. Need help washing and dressing. Can feed myself and comb hair.
☐ **Complete disability** of arm.

Please rate how your shoulder problem affects your ability to work.

☐ 4 Fully able to work
☐ 3
☐ 2
☐ 1
☐ 0 Unable to work

Please rate how your shoulder problem affects your ability to participate in sports or recreational activities.

☐ 4 Fully able to work
☐ 3
☐ 2
☐ 1
☐ 0 Unable to work

Please choose the highest level you are able to use your hands to perform tasks:

- ☐ Can use hands only at waist level
- ☐ Can use hands at chest level
- ☐ Can use hands at neck level
- ☐ Can use hands to the top of my head
- ☐ Can use hands at levels over my head

Shoulder Strength Assessment

Do you rely on your shoulders for work? □ Yes □ No

How important to you is shoulder strength to your occupation? (please circle one)

Not Important — Very Important

0 1 2 3 4 5 6 7 8 9 10

To what degree are you limited by loss of strength in your job? (please circle one)

Not Important — Very Important

0 1 2 3 4 5 6 7 8 9 10

To what degree are you limited by loss of strength on a day-to-day basis? (please circle one)

Not Important — Very Important

0 1 2 3 4 5 6 7 8 9 10

Are you actively involved in sports? □ Yes □ No

If so, which sports are you involved in: _____

Do you rely on your shoulders for sports? □ Yes □ No

How important to you is shoulder strength to your sport? (please cicrle one)

Not Important — Very Important

0 1 2 3 4 5 6 7 8 9 10

To what degree are you limited by loss of strengthin your sport? (please circle one)

Not Limited — Very Limited

0 1 2 3 4 5 6 7 8 9 10

If your good shoulder is 100% in strenght, what percentage is your injured shoulder?

_____%

Please rate the realitive importance of strength improvement following treatment (please circle one)

Not Important — Very Important

0 1 2 3 4 5 6 7 8 9 10

Please rate "How bad has your pain been on average over the LAST 7 DAYS?" (please circle one)

Not Important — Very Important

0 1 2 3 4 5 6 7 8 9 10

Please rate the realitive importance of pain relief following treatment (please circle one)

Not Important — Very Important

0 1 2 3 4 5 6 7 8 9 10

Following treatment of your shoulder condition, which outcome would you find more satisfactory to you? (please circle one)

A Strong Shoulder with Mild to Moderate Pain — A Weak Shoulder with No Pain

CURRENT HEALTH ASSESSMENT

In general, would you say your health is:

- ☐ Excellent
- ☐ Very Good
- ☐ Good
- ☐ Fair
- ☐ Poor

The following items are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?

	Yes, limited a lot	Yes, limited a little	No, not limited at all
Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	☐	☐	☐
Climbing several flights of stairs	☐	☐	☐

During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

	Yes	No
Accomplished less than you would like	☐	☐
Were limited in the kind of work or other activities	☐	☐

During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of emotional problems (such as feeling anxious or depressed)?

	Yes	No
Accomplished less than you would like	☐	☐
Didn't do work or other activities as carefully as usual	☐	☐

During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?

- ☐ Not at all
- ☐ A little bit
- ☐ Moderately
- ☐ Quite a bit
- ☐ Extremely

These questions are about how you feel and how things have been with you during the last 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling. How much of the time during the last 4 weeks:

	All of the time	Most of the time	A good bit of the time	Some of the time	A little of the time	None of the time
Have you felt calm and peaceful?	☐	☐	☐	☐	☐	☐
Did you have a lot of energy?	☐	☐	☐	☐	☐	☐
Have you felt downhearted and blue?	☐	☐	☐	☐	☐	☐

During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting friends, relatives, etc.)?

☐ All of the time ☐ Most of the time ☐ Some of the time ☐ A little of the time ☐ None of the time

Thank you for completing this information!