

# POSM / OFALS SHOULDER SUBJECTIVE NEW

Medical Record #

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Name: \_\_\_\_\_

Exam Date

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Injured Shoulder:  Right  Left  Both

MRI of shoulder better today  Yes  NO  
than previous

Hand you write with:  Right  Left  
 Ambidextrous (both)

Previous Surgery:  Right Shoulder  Left Shoulder

Gender:  Male  Female

Physician:  KP  EB  OTHER

Occupation: \_\_\_\_\_

## SPORTS PARTICIPATION INFORMATION

Primary Sport \_\_\_\_\_ Years Participated \_\_\_\_\_

What level of intensity is your sport? \_\_\_\_\_ Position Played \_\_\_\_\_

Recreational Part-time  High School  Pro-Minors  
 Recreational Full-time  College  Pro-Majors

At what regional level do you compete?

Local  Regional  National  International

Sport	Year
1	<input type="radio"/>
2	<input type="radio"/>
3	<input type="radio"/>
4	<input type="radio"/>
5	<input type="radio"/>
6	<input type="radio"/>
7	<input type="radio"/>
8	<input type="radio"/>
9	<input type="radio"/>
0	<input type="radio"/>

## INJURY AND TREATMENT HISTORY

What is the reason(s) for seeking medical attention?

- Pain  Cant' reach behind back or tie br  Can't weight lift  Loss of Shoulder function  
 Shoulder coming out  Cant' do overhead work  Can't throw a ball  Stiffness  
 Reach behind back  Can't go across body  Weakness  Other \_\_\_\_\_

Date of onset symptoms: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Did you have an injury at onset of symptoms?  No  Yes

If yes, was it Sports Related?  No  Yes

what sport? \_\_\_\_\_

Describe how injury occurred: \_\_\_\_\_

Is there a worker's compensation claim involved with your injury?  No  Yes

Have you had supervised physical therapy?  No  Yes

Did you try other treatments such as:  Ultrasound  TENS  Electical Stimulation  Other \_\_\_\_\_

Has your shoulder been injected?  Yes  No

If YES, how many times?  once  twice  3 to 5  6 or greater

If YES, with what steroid?  Orthovisc  Euflexxa  Supartz  Synvisc  Hyalgan

Thirty minutes after the latest injection, how much improvement did you have?

Worse  0-25%  26-50%  51-75%  76-100%

What was the long-term effect of the injection?

Worse  0-25%  26-50%  51-75%  76-100%



Have you had previous shoulder surgery (on your injured shoulder)?  Yes  No

*If yes, please complete the following:*

Surgery 1: \_\_\_\_\_ Date:  /  /   
 Shoulder:  R  L  
 Amount of Maximum Improvement:  Worse  0-25%  25-50%  50-75%  75-100%

Surgery 2: \_\_\_\_\_ Date:  /  /   
 Shoulder:  R  L  
 Amount of Maximum Improvement:  Worse  0-25%  25-50%  50-75%  75-100%

**PAIN EVALUATION**

**How bad is your pain at the following times on a scale of 0 to 10 ?**

**No Pain** **Very Bad Pain**

Today:  0  1  2  3  4  5  6  7  8  9  10  
 At its worst:  0  1  2  3  4  5  6  7  8  9  10

Is your Pain  No Pain  Getting Better  Staying the Same  Getting worse

**Do you take narcotic pain medications?**  Yes  No  Type \_\_\_\_\_

**If yes,** are they beneficial?  Yes  No How many pills/day?  1  2  3 to 5  6 or greater

**Do you take anti-inflammatories?**  Yes  No  Type \_\_\_\_\_  History of Ulcers \_\_\_\_\_

**If yes,** are they beneficial?  Yes  No

**How does your pain affect:**

your activities of daily living?  None  Very Mild  Mild  Mild to Moderate  Moderate  Moderate to Severe  Severe  
 your function at work?  None  Very Mild  Mild  Mild to Moderate  Moderate  Moderate to Severe  Severe  
 your recreational sporting activities?  None  Very Mild  Mild  Mild to Moderate  Moderate  Moderate to Severe  Severe  
 your sleep?  None  Very Mild  Mild  Mild to Moderate  Moderate  Moderate to Severe  Severe

**How much pain do you have with your arm at rest by your side?**

None  Very Mild  Mild  Mild to Moderate  Moderate  Moderate to Severe  Severe

**With regard to your sport, how does pain affect (leave blank if not active in sports):**

your endurance  None  Very Mild  Mild  Mild to Moderate  Moderate  Moderate to Severe  Severe  
 your speed  None  Very Mild  Mild  Mild to Moderate  Moderate  Moderate to Severe  Severe  
 your accuracy or agility  None  Very Mild  Mild  Mild to Moderate  Moderate  Moderate to Severe  Severe

**How does your pain affect your ability to compete (leave blank if not active in sports)?**

No pain with competition  Moderate pain with competition  
 Pain only after competition  Severe pain with competition  
 Mild pain with competition  Pain prevents competition

**SHOULDER INSTABILITY**

Have you had a shoulder dislocation that someone else had to put back in?  Yes  No

If yes, how many?  1  2  3 to 5  6 or greater

How often does your shoulder feel like it will  Never  Rarely  Occasionally  Frequently

Has it ever gone out in your sleep?  Yes  No

Answer the following only if you feel like your shoulder will go out:

Does this instability occur with:  Sports  Activities of Daily Living  Sleep  
 Which direction does it go out:  Front  Back  Bottom  All  Unknown  
 How does your shoulder go back in?  By Itself  I pull on my arm  Someone else assists  
 How many time does this occur each month?  0-2  3-5  6-10  11-15  more than 15  
 How is your shoulder instability changing with time:  Improving  Unchanged  Getting Worse

**How does your shoulder instability affect your ability to compete in sports? Leave blank if not applicable.**

No problems during competition  I occasionally have to stop competing  
 I have instability, but can continue to compete  I frequently have instability and have to stop competing  
 I rarely have to stop competing  I cannot compete due to instability

**Does a certain position of your arm interfere with your performance?**

No  Yes, with my arm above my head  Yes, with my arm in front of my body



