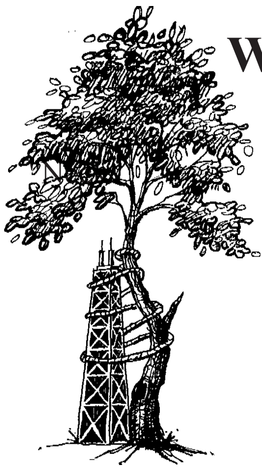


WINDY CITY ORTHOPEDICS & SPORTS MEDICINE

2617 W. Peterson Avenue   Chicago, Illinois 60659

Toll Free 877-549-4490   Suburban 847-475-0200   Chicago 773-743-1981

TODAY'S DATE ______/______/______

PATIENT INFORMATION QUESTIONNAIRE: SHOULDER

NAME____
FIRST   MIDDLE   LAST

HEIGHT ____________   WEIGHT _____________   AGE __________

I AM RIGHT HANDED   I AM LEFT HANDED (Please Circle)

WHAT KIND OF WORK DO YOU DO? (Please Circle) Construction   Desk Job   Driving   Teacher

Executive/Professional   Factory   Homemaker   Retired   Sales   Student

Other (Please List) ____

IF YOU ARE NOT WORKING NOW, WHEN DID YOU LAST WORK? ______/______/______

DOES IT REQUIRE LIFTING? HOW OFTEN DO YOU LIFT THESE WEIGHTS? (Please Circle)

None   10 lbs. or less   10-50 lbs.   50-100 lbs   More than 100 lbs.

Rarely   Frequently   Constantly

AS PART OF YOUR WORK DO YOU COMMONLY? (Please Circle All Those That Apply)

Squat   Push   Pull   Lift Overhead   Climb Ladders/Stairs   Reach   Bend   Stoop

IS THIS A WORKMAN'S COMPENSATION CASE? (Please Circle)   Yes   No

Company Name ______________________________ Company Phone (_______)______________

Company Address ____
STREET   CITY   STATE   ZIP

IS THIS A LEGAL OR THIRD PERSON LIABILITY CASE? (Please Circle)   Yes   No

Lawyer's Name ______________________________ Lawyer's Phone (_______)______________

Lawyer's Address ____
STREET   CITY   STATE   ZIP

WHICH JOINT(S) ARE YOU HAVING TROUBLE WITH? (Please Circle Those That Apply)

Right: Shoulder   Elbow   Wrist   Hand   Fingers   Hip   Knee   Ankle   Foot   Toes

Left: Shoulder   Elbow   Wrist   Hand   Fingers   Hip   Knee   Ankle   Foot   Toes

Neck   Back   Left Buttock   Right Buttock   Left Groin   Right Groin   Left Thigh   Right Thigh

Other (Please List) ____

____

PLEASE CIRCLE YOUR ONE MAJOR COMPLAINT ! PLEASE CHECK (✔) ANY OTHER COMPLAINTS

Back or Neck Pain	Shoulder or Upper Arm Pain	Shooting Pains into the Elbow/Hand
Deformity	Instability/Popping Out	Deformity
Grinding/Popping/Noises	Something Moving Inside	Driving/Sitting
Locking/Catching	Loss of Activities/Work	Loss of Motion
Aching/Soreness	Reading	Numbness/"Burners"
Sports /Throwing are Limited	Stiffness Swelling	Weakness

Difficulty With: Eating   Lifting   Personal Hygiene   Putting on Clothes or a Jacket   Writing/Typing

Any Other Complaints____

____

HAVE YOU EVER HAD A SHOULDER/ELBOW INJURY OR PAIN? YES NO (See Last Page for Surgery)

WHEN? ____

____

ONSET OF THE PROBLEM:

Suddenly But **No Known Injury:** On ____/____/____

_______ Days Ago _______ Weeks Ago _______ Months Ago _______ Years Ago

An Injury : On ____/____/____

_______ Days Ago _______ Weeks Ago _______ Months Ago _______ Years Ago

I Don't Know When ________________ Gradually Since ____

Other____

HAVE YOU MISSED WORK/PRACTICE BECAUSE OF YOUR SHOULDER OR ELBOW? Yes No

How long have you been off work? ____ days ____weeks ____ months _______ Since the Injury

If you have returned to work, when did you return? ____week(s) ago ___ month(s) ago On ____/____/____

HAVE YOU BEEN ON LIGHT OR LIMITED DUTY BECAUSE OF YOUR SHOULDER OR ELBOW? Yes No

INJURED WHILE:(Please Circle All Those That Apply)

Falling	Hit By Object	Running/Jumping
Hit By Another Player	Slipped on Ice/Water/Oil	Tripping
Noncontact	Pulling/Pushing	Reaching
Twisting	Vehicle Accident	Ankle/Foot was run Over

Other____

____

INJURED DURING:(Please Circle)

Aerobics	Basketball	Baseball
Bicycling	Football	Handball
Racquetball	Running	Soccer
Skiing	Tennis	Volleyball

Other ____

____

IF THIS WAS AN INJURY ON THE JOB, PLEASE FILL OUT THIS SECTION

Injury At Work On ___________________________ Time of Day ______ AM PM

Was any equipment, machinery and/or object involved in the accident? Yes No

If yes,please explain ____

____

Was the accident reported to your supervisor and/ or employer at the time of the injury? Yes No

IF THIS WAS A MOTOR VEHICLE ACCIDENT,PLEASE FILL OUT THIS SECTION

Vehicle Accident On _____/_____/_____ Time of Day ______ AM PM

Were You? (Please Circle) Driver Passenger Pedestrian Wearing a Seatbelt? Yes No

Did you strike your head or lose consciousness? Yes No

If you were passenger,what was your position in the vehicle? ________________________________

What kind of vehicle(s) was/were involved in the accident? (Please circle your type of vehicle and place a check (✔) over the other) Truck Van Car Motorcycle

Other ____

Was the collision?: Rear end Headon "T" Type Sideswipe Struck on the Left Struck on the Right

Multiple Vehicle "Daisy Chain" Other ____

____

Was your vehicle moving when it was struck? Yes No How fast was it going? _____________________

Was the accident reported to the police? Yes No

What was the weather? ____

Did your vehicle strike another vehicle or object? Yes No Please Describe: ______________________

____

Other ____

____

IF YOU ARE EXPERIENCING **PAIN:** PLEASE ANSWER THIS SECTION.

IF NOT, PLEASE CIRCLE **NO PAIN** AND SKIP TO THE NEXT PAGE

Overall, Since It Started, Is Your Pain? (Please Circle) Getting Better Getting Worse Staying the Same

Overall, How Much is the Pain Better or Worse ? (Please Circle) 0% 10% 25% 50% 75% 90%

On Average, I have ______% Good Days ______ % Bad Days ______ % Average Days

LOCATION OF THE PAIN (Please Circle The Major Pain and Check (✔) Any OthersThat Apply)

Front	Top	Collarbone	Neck
Back	Outer Side	All Over	Armpit
Shoulder Blade	Chest	Deep Inside the Center of the Shoulder	

THE PAIN GOES TO: (Please Circle All Those That Apply)

Between My Shoulder Blades Arm Elbow Fingers

Back of the Hand Palm of the Hand Back of the Head

WHERE DID YOUR PAIN START? ____________________

WHERE DID YOUR PAIN SPREAD?(If Anywhere) ____________________

AT THE TIME OF INJURY, DID YOU FEEL A RIP, POP OR TEARING? YES NO

FREQUENCY OF THE SHOULDER OR ELBOW PAIN: (Please Circle All Those That Apply)

Initially, But Not Now	Recent Onset	Even When Resting
Constantly /All Day	Irregularly	Occassionally
Every Day	Most Days	Some Days
Unpredictable	In the Morning	With or After Activity/Sports

Other ____________________

TIME OF DAY WHEN THE SHOULDER OR ELBOW PAIN OCCURS: (Please Circle All Those That Apply)

Morning	Good & Bad Days	No Apparent Pattern to the Pains
All Day/Constant	Unpredictable	Late In The Day
Irregular	At Work	Interrupts My Sleep/At NIght

Other____________________

HOW OFTEN DOES THE PAIN CAUSE DIFFICULTY GOING TO SLEEP OR WAKE YOU UP AT NIGHT?

Never Rarely/Sometimes Most Nights Every Night

I Can Sleep But Only When I Take Medicine I Can't Sleep Even When I Take Medicine

BECAUSE OF MY SHOULDER OR ELBOW PAIN, I HAVE TO SLEEP : (Please Circle)

On My Back	On My Stomach	On The Side of The Unaffected Shoulder
Sitting Up	Affected Arm At my Side	On the Side of the Affected Shoulder

Affected Arm Up, Shoulder Between My Head and Mattress

THE SHOULDER OR ELBOW PAIN IS: (Please Circle All Those That Apply)

Sharp/Knifelike	Dull	Aching
Electric Shock	Burning	Throbbing
Tingling	Cold	Increased by Weather Changes

Other____________________

THE SHOULDER OR ELBOW PAIN IS MADE WORSE WHEN: (Please Circle All Those That Apply)

Carrying Objects	Combing My Hair	Eating	Dressing
Driving or Sitting	Fastening a Bra	Opening a Jar	Pulling on Pants or Skirt
Pushing	Reaching Back	Reaching Out	Reaching Behind Head
Resting	Throwing	Using Tools	With any Movement
Weather Changes	Writing or Typing	Personal Hygiene Arm	

Going into My Back Pocket/Tucking in My Shirt Lifting or Reaching Overhead Washing Under My Opposite Arm

Other____________________

THE SHOULDER OR ELBOW PAIN IS RELIEVED BY: (Please Circle All Those That Apply)

Nothing	Rest	Activity
Moving the Shoulder/Elbow	Heat	Cold
Medicine	Cortisone Injection	Physical Therapy

Other____________________

____

DO YOU HAVE PAIN WITH LIFTING:	TO EYE LEVEL		OVERHEAD	
Weight of Arm Only	Yes	No	Yes	No
Telephone Book or 1 Pint of Milk (1-2 lbs.)	Yes	No	Yes	No
Sack of Flour or 1 Gallon of Milk (5-10 lbs.)	Yes	No	Yes	No
A Small Child (25-50 lbs.)	Yes	No	Yes	No
50-100 lbs.	Yes	No	Yes	No
More Than 100 lbs	Yes	No	Yes	No

PLEASE CIRCLE THE NUMBER THAT CORRELATES BEST WITH HOW FAR YOU ARE FROM NORMAL TOWARD THE WORST POSSIBLE SITUATION YOU CAN IMAGINE OR HAVE EVER SUFFERED

0 1-2 3-4 5-6 7-8 9-10

0 = No pain or limitation at all. 10 = The worst possible pain or limitation that you can ever imagine.

How bad is your pain today?	0	1	2	3	4	5	6	7	8	9	10
How bad is the pain at the worst its ever been?	0	1	2	3	4	5	6	7	8	9	10
How bad is the pain at the best its ever been?	0	1	2	3	4	5	6	7	8	9	10
Does the pain interfere with your lifestyle?	0	1	2	3	4	5	6	7	8	9	10
Does the pain interfere with your work?	0	1	2	3	4	5	6	7	8	9	10
Do you have pain lying in bed or at rest?	0	1	2	3	4	5	6	7	8	9	10

NONPAIN SYMPTOMS/COMPLAINTS

MAXIMUM WEIGHT YOU CAN PUSH OR PULL: None 25-50 lbs. 100 lbs. More than 100 lbs.

MAXIMUM WEIGHT YOU CAN CARRY: (Please Circle) Weight of the Arm Only

Brief Case (5-10 lbs.) Shopping Bag (10-15 lbs.) Suitcase (25-30 lbs.) More Than 50 lbs.

IS YOUR SHOULDER OR ELBOW STIFF? (Please Circle All those That Apply)

Never	Always	After Activity or Sports
With Weather Changes	In the Morning	At the End of the Day
When Driving or Sitting	With Walking	

Other____

SHOULDER OR ELBOW RANGE OF MOTION: (Please Circle All those That Apply)

Normal	Can't Reach My Waist	Can't Reach My Opposite Shoulder
Can't Lift My Shoulder At All	Can't Lift Arm Overhead	Can't Bring My Hand To My Mouth
Can't Comb My Hair	Can't Reach Back	Can't Reach Forward

Other____

DO YOU FEEL CRUNCHING, POPPING, GRINDING, GRATING, SNAPPING OR "FUNNY NOISES" IN THE SHOULDER OR ELBOW? (Please Circle)

Never	The Noises are New	The Noises are Old
The Noises are Painless	The Noises are Painful	Noticeable When Lifting
I Can Feel Them With My Hand	I Can Hear Them	

Where?____

CAN YOU THROW A SOFT BALL UNDERHAND 10 YARDS WITH THE BAD ARM? Yes No

CAN YOU THROW A SOFT BALL OVERHAND 20 YARDS WITH THE BAD ARM? Yes No

IF YOU HAVE PAIN WITH THROWING,IS IT? : **I DON'T HAVE PAIN WHEN THROWING**

During the Game	After the Game (The Same Day)	The Next Day
During the Windup	During the Throw	During the Follow Through

WHICH SPORTS MAKE THE PAIN WORSE? (Please List) ____

DO YOU FEEL THAT THE SHOULDER MUSCLES HAVE "SHRUNKEN" OR ATROPHIED?	YES	NO
IS YOUR ARM COMFORTABLE AT YOUR SIDE?	YES	NO
HAVE YOU EVER HAD TO USE A SLING OR SHOULDER IMMOBILIZER?	YES	NO

DOES THE SHOULDER OR ELBOW SWELL? (Please Circle All Those That Apply)

Never	Initially, But Not Now	Recent Onset	Even When Resting
Constantly/All Day	Irregularly/ Unpredictable	Occassionally	Every Day
Most Days	Some Days	In the Morning	With or After Activity/Sports

Other ____

DOES THE SHOULDER OR ELBOW GET "STUCK" OR "LOCK UP"? (Please Circle All Those That Apply)

Never	Constantly	At First But Not Now
While Throwing	Frequently	Catches But Does Not Truly Lock
Just Started	At Night	While Throwing

Daily _____ Weekly _____ Monthly ______ How Many Total Times?________

IS THE SHOULDER/ELBOW UNSTABLE,"POP OUT" OR DISLOCATE? (Please Circle All Those That Apply)

Never	When Asleep	Putting On A Shirt or Coat
At The Present Time	While Throwing	I Can Pop It Out Any Time I Want
Unexpectadly/Unpredictable	My Arm Goes "Dead"	I Can't Control When It Pops Out

Only At The Time Of The Original Injury During Sports

How Often: Daily ______ Weekly _____ Monthly _____ Has Happened a Total Of ______ Times

How and When Did it Occur The First Time? ____

____

DO YOU HAVE WEAKNESS IN THE SHOULDERS, ARMS OR HANDS? YES NO

Where?____

DO YOU DROP THINGS OR HAVE PROBLEMS WITH "CLUMSINESS"? YES NO

DO YOU HAVE NUMBNESS,TINGLING, OR "PINS AND NEEDLES"? (Please Circle All those That Apply)

NONE	At Night	At First But Not Now
Constantly	Intermittent	Numbness/Tingling
"Funny Feelings"	Pins & Needles	Burning

Where?____

ACTIVITIES YOU CAN <u>NOT</u> DO BECAUSE OF THE SHOULDER OR ELBOW:(Please Circle All those That Apply)

None	Sleep	Sleep On My Shoulder	Typing/Writing
Put on clothes	Shopping	Housework	Reading
Yardwork	Eat Or Feed Myself	Sitting/Driving	Personal Hygiene

Putting Something on a High Shelf

Recreational activities I enjoy (Please List)____

____

MAXIMUM Time That You Can Sit/Drive: ______ Minutes ______ Hours Unlimited

HAVE YOU EVER RUPTURED YOUR BICEPS TENDON? YES NO If so, when? __________________

HAVE YOU EVER BROKEN A BONE? (Please List and Date Each)

____

____

HAVE YOU EVER DISLOCATED ANY OTHER JOINT? (Please List and Date Each)

____

____

WHICH SPORTS DO YOU (OR WOULD LIKE TO) PARTICIPATE IN?ARE LIMITED IN THEM?(Please List)

____

____

HAVE YOU OR DO YOU PARTICIPATE IN COMPETITIVE SPORTS AND AT WHAT LEVEL? (Please List)

____

____

HAVE YOU TAKEN ANY MEDICATIONS FOR THE PAIN? YES NO

(Please Circle Your CURRENT Medications and Check (✔) Any OthersThat You Have Taken in the Past)

Pain Medication	Antiinflammatory Drugs		Muscle Relaxants/Neuro Drugs
Darvocet-N-100(propoxyphene)	Motrin/Ibuprofen/Advil	Daypro(oxaprozin)	Dantrium(dantrolene)
Tylenol #3 (codeine)	Aspirin	Clinoril (sulindac)	Flexeril (cyclobenzaprene)
Vicodin/Norco (hydrocodone)	Naprosyn(Aleve)	Lodine(etodolac)	Skelaxin(metaxalone)
Oxycontin/Oxycodone	Celebrex (celecoxib)	Limbrel	Soma (carisoprodal)
Percodan (oxycodone)	Mobic (meloxicam)	Indocin(indomethacin)	Robaxin(methocabamol)
Tylenol (acetaminophen)	Voltaren(diclofenac)	Relafin(nabumetone)	Neurontin (gabapentin)
Ultram (tramadol)	Feldene (piroxicam)	Nalfon (fenoprofen)	Lyrica(pregabalin)
Duract (bromfenac)	Trilisate (trisalicylate)	Glucosamine	Requip (ropinorole)

Other ____________________

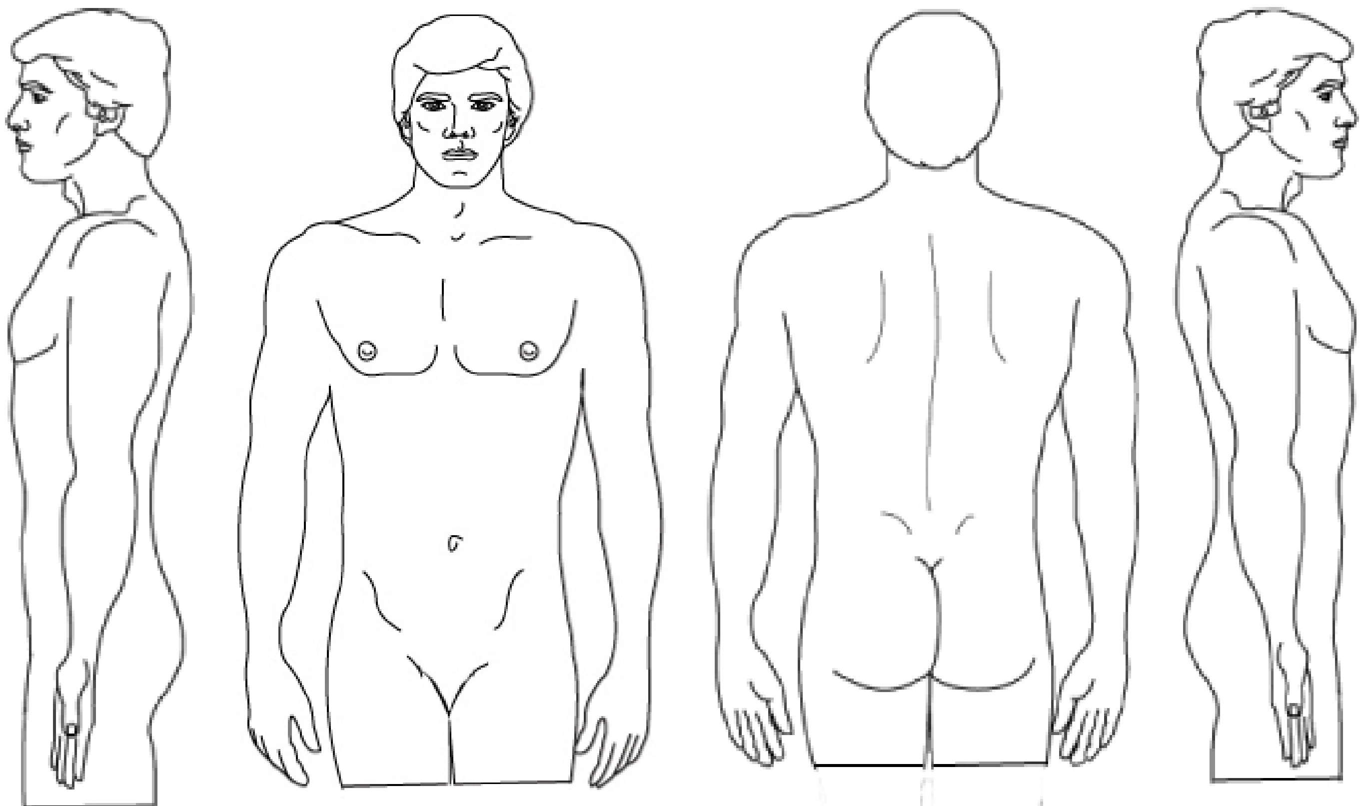
Have you ever had a Cortisone injection or a Prednisone/Medrol dose pack? Yes No How Many? 1 2 3 4 5 >5

Do you use any Herbal Medicine?____________________

DOES THE MEDICATION HELP? Yes No Only A Little Bit

WHERE IS YOUR PAIN? (Please mark on the drawings where you feel the specific type pain or sensation)

Burning XXXX Throbbing ✔✔✔✔ Sharp /////////// Aching ●●●●● Numbness ✻✻✻✻



Left Front Back Right

WERE YOU TREATED FOR THIS PROBLEM BY YOUR FAMILY PHYSICIAN? YES NO

Name ______________________ When ______________________

Diagnosis______________________ Treatment ______________________

WERE YOU TREATED FOR THIS PROBLEM BY AN ORTHOPEDIC SURGEON? YES NO

Name ______________________ When ______________________

Diagnosis______________________ Treatment ______________________

WERE YOU TREATED FOR THIS PROBLEM BY A CHIROPRACTER OR NAPROPATH? YES NO

Name ______________________ When ______________________

Diagnosis______________________ Treatment ______________________

HAVEYOU EVER HAD X-RAYS TAKEN OF YOUR SHOULDER OR ELBOW? YES NO

When ______________________ Where ______________________

Results ______________________

HAVEYOU EVER HAD AN ARTHROGRAM (dye test) DONE? YES NO

When ______________________ Where ______________________

Results______________________

HAVEYOU EVER HAD A CAT SCAN OR MRI OF YOUR SHOULDER OR ELBOW DONE? YES NO

When ______________________ Where ______________________

Results______________________

WERE YOU TREATED FOR THIS PROBLEM IN AN EMERGENCY ROOM? YES NO

Hospital ______________________ When ______________________

Diagnosis ______________________ Treatment ______________________

HAVE YOU EVER HAD PHYSICAL THERAPY (PT) OR A BRACE FOR THIS PROBLEM? YES NO

When ______________________ Where ______________________

Results ______________________

HAVE YOU EVER HAD SURGERY FOR YOUR SHOULDER OR ELBOW? YES NO

#1 When ____________ Hospital ______________________

Open Surgery________ Arthroscopic Surgery _____ Doctor ______________________

Procedure ______________________

Results______________________

#2 When____________ Hospital ______________________

Open Surgery________ Arthroscopic Surgery _____ Doctor ______________________

Procedure ______________________

Results______________________

#3 When____________ Hospital ______________________

Open Surgery________ Arthroscopic Surgery _____ Doctor ______________________

Procedure______________________

Results______________________

#4 When____________ Hospital ______________________

Open Surgery________ Arthroscopic Surgery _____ Doctor ______________________

Procedure______________________

Results ______________________

THANK YOU FOR PATIENCE IN FILLING OUT THIS FORM!