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SHOULDER CLINICAL QUESTIONNAIRE

WHICH SHOULDER? ☐ RIGHT ☐ LEFT

NAME: ______________________________ DATE: ____________________

1. Why has your doctor sent you for this test? Did he/she give you a specific diagnosis?
 ____
 ____
2. Please describe what specific complaints/symptoms have been most bothersome to you?
 ____
 ____
3. How long have you had these complaints/symptoms? ____________________
4. Did these complaints/symptoms come on suddenly or gradually? ____________________
5. Are these symptoms the: ☐ same ☐ better ☐ worse
6. Please check if you have any of the following:
 - ☐ Neck pain on the same side
 - ☐ Difficulty raising your arm
 - ☐ Numbness, tingling, weakness, or pain radiating down the same arm
7. Have you ever had a prior shoulder injury (including dislocation) ☐ yes ☐ no
 If yes, please describe: ____________________
8. Have you ever had surgery on this shoulder ☐ yes ☐ no
 - ☐ Arthroscopic When and Where: ____________________
 - ☐ Open Surgery When and Where: ____________________
 - ☐ Shoulder Replacement When and Where: ____________________
9. Have you ever had an Arthrogram on this shoulder? ☐ yes ☐ no
 If yes, when and where? ____________________