MUNSON HEALTHCARE
ORTHOPEDIC INSTITUTE

Shoulder Form

Name: ______________________________Age: ________ How were you referred? ____________________________________

Occupation: ____

Treatments you would like to discuss: ____

Problem Shoulder:

- ☐ Right
- ☐ Left
- ☐ Both shoulders

How long has the pain been present?

____

Dominant hand:

- ☐ Right
- ☐ Left

Pain is:

- ☐ Mild
- ☐ Moderate
- ☐ Severe

Pain is getting

- ☐ Worse
- ☐ Better
- ☐ Unchanged recently

Have you tried:		When	Helpful?
Physical therapy	Y/N	______	Y/N
Injections	Y/N	______	Y/N
OTC meds	Y/N	______	Y/N
Rest	Y/N	______	Y/N
Heat/Ice	Y/N	______	Y/N

Changes in your sleep

- ☐ Yes
- ☐ No

History of surgery on your shoulder Y/N

Tobacco use Y/N

Diabetes Y/N

Anything else you would like us to know?____
____
____

Doctor to fill out

ROM	**FE**	**ER**	**IR**
	R: _________	__________	___________
	L: _________	__________	___________

PLAN:

MRI	**CT**	**INJ**	**Rest**
Surgery	**Meds**	**PT**	