Bahri Orthopedics & Sports Medicine Clinic, P.L.

Shoulder History

Name:_____Date:_____Age: _____

Shoulder Problem: _____ ○ Right ○ Left

Are you generally: Right handed or Left Handed? (circle one please)

Date of Onset:_____Injury: ○ Yes ○ No *(Describe Injury)* _____

How Did Pain or Problem Begin? _____

_____

_____

_____

Symptoms

Is your shoulder problem	Intermittent	constant
Soreness/Aching	Yes	No
Pain ○	Yes	○ No
Pain with reaching or overhead activities	○ Yes	○ No
Popping, clicking, grinding	○ Yes	○ No
Loss of motion	○ Yes	○ No
Stiffness	○ Yes	○ No
Weakness	○ Yes	○ No
Numbness	○ Yes	○ No
Tenderness	○ Yes	○ No
Does shoulder pain wake you or keep you awake?	○ Yes	○ No
Neck and /or arm pain	○ Yes	○ No
Can you sleep on the affected side?	○ Yes	○ No
Past shoulder problems	○ Yes	○ No
Are you in good general health?	○ Yes	○ No
	○	○
	○	○

6100 Kennerly Rd., Ste. 101 • Jacksonville, FL 32216 • **904-739-0050** • Fax: 443-2888
1045 Riverside Ave., Ste. 110 • Jacksonville, FL 32204 • **904-739-0050** • Fax: 443-2888
appointments@bahriorthopedics.com