Shoulder History

Name: ___________________________ Date: _______________ Age: __________

Shoulder Problem: _______________________________________________________

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 or constant

Soreness/Aching

Pain

Pain with reaching or overhead activities

Popping, clicking, grinding

Loss of motion

Stiffness

Weakness

Numbness

Tenderness

Does shoulder pain wake you or keep you awake?

Neck and/or arm pain

Can you sleep on the affected side?

Past shoulder problems

Are you in good general health?

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