Upper Extremity Symptom and Pain Questionnaire

Last Name: ___________________________ First Name: ___________________________ Middle Initial: ___________________________

Date of Birth: ____________________ Age: _____________ Occupation: _______________________________________________________

Reason for visit: __________________________________________________________

Which side: ☐ Right ☐ Left ☐ Both Approximate date of onset: _______________________________________________________

Please indicate which apply: ☐ Sports injury ☐ Work injury ☐ Motor vehicle accident

☐ Other (please describe): _______________________________________________________

Describe how you injured your shoulder and/or upper extremity: _______________________________________________________

Are you: ☐ Right handed ☐ Left handed

Rate your pain discomfort (circle one): None 1 2 3 4 5 6 7 8 9 10 Severe

Major complaint: ☐ Pain ☐ Swelling ☐ Slipping out ☐ Locking ☐ Loss of motion ☐ Grinding ☐ Buckling ☐ Instability ☐ Popping

☐ Other _______________________________________________________

Pain is: ☐ Constant ☐ Frequent ☐ Occasional ☐ Sharp ☐ Throbbing ☐ Burning ☐ Electric shot ☐ Nothing

Location of pain: ☐ Front ☐ Back ☐ Side ☐ Chest ☐ Up into the neck ☐ Down the Arm

☐ Other (please describe): _______________________________________________________

Pain associated with: ☐ Reaching ☐ Sleeping ☐ Throwing ☐ Overhead activity

☐ Other (please describe): _______________________________________________________

Pain relieved by: ☐ Rest ☐ Activity ☐ Heat ☐ Ice ☐ Other (please describe): _______________________________________________________

☐ Medication (if so, which): _______________________________________________________

Distance you can walk without pain: ☐ Unlimited ☐ Short distances (how many blocks?): _______

☐ Other (please describe): _______________________________________________________

How many aisles in supermarket? _______ ☐ House bound

Treatment to date (check all that apply):

☐ Medication (list): _______________________________________________________

☐ Cortisone injection

☐ MRI/X-ray (when & where): _______________________________________________________

☐ Physical therapy (if so how long & what result): _______________________________________________________

☐ Surgery (please describe): _______________________________________________________

Surgeon: ___________________________ Date: ___________________________

☐ Other: _______________________________________________________

Are you experiencing numbness in the arm? ☐ No ☐ Yes

Can you dislocate your shoulder on your own? ☐ No ☐ Yes

Patient signature: __________________________________________ Date: ___________________________