

Shoulder Database Rehabilitation

IMPORTANT - Please complete the entire form. If you need help in filling out the form, we are happy to help.

| Date: | | | | | |
|-------------|----------------------------------|-----------|------|----------|--|
| Name: | | Date of B | | | |
| Address: | | | MR # | <u> </u> | |
| Height: | Weight: | Sex: M | F | Age: | |
| Primary MD: | | | | | |
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| | | | | | |
| | ss: | | | | |
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| | | | | | |
| • | ions/Surgeries <i>(Enter Yea</i> | | | | |
| | | | | | |
| ' | | | | | |

| Medical Problems: |
|--|
| Allergies/Reaction: (Include the medication or food allergy and the reaction) |
| Current Medications: (Include name and dose of all medications, including over-the-counter, antacids, laxatives, birth control pills and vitamins) |

REVIEW OF SYSTEMS

Do you have currently or ever have the following?

| General: | | | Skeletal: | | |
|-------------------------------------|----|-----|-----------------------|----|-----|
| Unexplained weight loss/gain | | Yes | Pain | No | Yes |
| Recurrent/Unexplained fevers/chills | | Yes | Joint swelling | No | Yes |
| | | | Scoliosis | No | Yes |
| Cardiovascular: | | | Back/Neck problems | No | Yes |
| Chest Pain | No | Yes | | | |
| Dizzy Spells | No | Yes | Neurological: | | |
| Irregular Heart Rate | No | Yes | Unconsciousness | No | Yes |
| High Blood Pressure | No | Yes | | | |
| | | | Hematological: | | |
| Respiratory: | | | Bruise easily | No | Yes |
| Persistent Cough | No | Yes | Blood clots | No | Yes |
| Shortness of Breath | No | Yes | | | |
| Wheezing | No | Yes | Immunologic: | | |
| Blood in sputum | No | Yes | Recurrent infections | | |
| Lung disease | No | Yes | requiring antibiotics | No | Yes |
| Asthma | No | Yes | | | |
| Hay fever | No | Yes | Psychological: | | |
| Tuberculosis | No | Yes | Depression/Anxiety | No | Yes |
| | | | Sleep problems | No | Yes |

| Any other problems we sho | ould be aware of? | | | |
|---------------------------------|------------------------------|--|----------------|--|
| Family History: | | Social History: | | |
| Heart Disease | No Yes | Do you smoke? | No Yes | |
| Cancer | No Yes | If yes, how many cigarett | es per day? | |
| Diabetes | No Yes | | | |
| Kidney Disease | No Yes | Do you drink alcohol? | No Yes | |
| Arthritis | No Yes | If so, how many drinks per week? | | |
| | | | | |
| CURRENT PROBLEM | | | | |
| What problem are you seei | ng the doctor for today? | | | |
| What makes it better? | | Worse? | | |
| Is this the result of an injury | v? If ves. explain. | | | |
| | | | | |
| | | Date of injury? | | |
| Is this Workman's Compens | sation? Y / N | | | |
| Do you have a lawyer? Y / | N | | | |
| Is there litigation involved (| awsuit)? Y / N | | | |
| What other treatment have | • | | | |
| Chiropractor Y/N F | | | | |
| What tests have you had? | X-rays Y/N MF | RIY/N EMGY/N (| CT scan Y/N | |
| | | | | |
| SHOULDER ASSESSM | | | | |
| Are you having pain in your | | S | | |
| Do you have pain in your sh | _ | Yes | | |
| Is your shoulder comfortab | le with your arm at rest | or by your side? No Yes | | |
| Does your shoulder allow y | ou to sleep comfortably | ? No Yes | | |
| Can you reach the small of | your back to tuck in you | ur shirt with your hand? No | Yes | |
| How bad is your pain today? | ? No pain at all—o—c | ······································ | -o—Severe pain | |
| Do you take pain medication | on (aspirin, Advil, Tylenol, | , etc.)? No Yes | | |
| Do you take narcotic pain r | nedication (codeine or s | stronger)? No Yes | | |
| On average, how many pills | do you take each day? | pills | | |
| Can you place your hand be | ehind your head with the | e elbow straight out to the side? | No Yes | |
| Can you place a coin on a sl | nelf at the level of your sl | houlder without bending your elbo | w? No Yes | |

Can you lift one pound (a full pint container) to the level of your shoulder without bending your elbow? No Can you lift eight pounds (a full gallon container) to the level of the top of your head without bending your elbow? No Can you carry 20 pounds (bag of potatoes) at your side with the affected extremity? Yes Do you think you can toss a softball underhand 10 yards with the affected extremity? No Yes Do you think you can throw a softball overhand 10 yards with the affected extremity? Yes Can you wash the back of your opposite shoulder with the affected extremity? No Yes Does your shoulder allow you to work full-time at your regular job? No Does your shoulder feel unstable (as if it is going to dislocate)? No Yes How unstable is your shoulder? Very stable—o—o—o—o—o—o—o—o—Very unstable

CIRCLE THE NUMBER IN THE BOX THAT INDICATES YOUR ABILITY TO DO THE FOLLOWING ACTIVITIES:

0 = unable to do 1 = very difficult to do 2 = somewhat difficult 3 = not difficult at allActivity Right Arm Left Arm Put on a coat Sleep on your painful or affected side Wash back / clasp bra in back Manage toileting Comb hair Reach a high shelf Lift 10 pounds above your shoulder Throw a ball overhand Do usual work. List: Do usual sport. List:_____

DIAGRAM

Mark the areas on the picture below where you feel the described sensations.

Use the markings below to indicate sensations

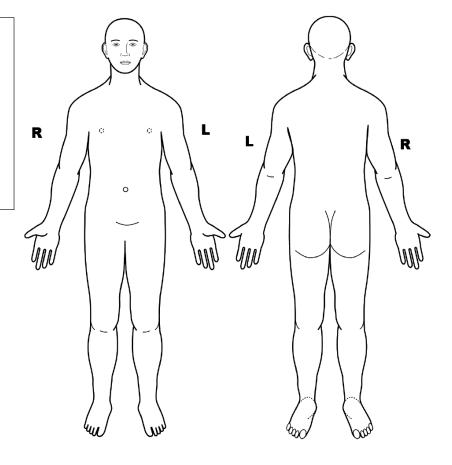
Pain: XXXXXXX

Numbness: 0000000

Pins & Needles: ++++++

Burning: **BBBBBB**

Stabbing: //////



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For more information on health topics and Loyola services, please visit our website at **www.loyolamedicine.org**





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