



Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

**Shoulder Intake Survey:**

**1. In general, would you say your health is:**

Excellent                  Very Good                  Good                  Fair                  Poor

**2. How much difficulty do you have combing/brushing your hair using your affected arm?**

Unable to perform                  A lot                  Some                  A little                  None

**3. How much difficulty do you have to reach a shelf that is shoulder height using your affected arm?**

Unable to perform                  A lot                  Some                  A little                  None

**4. How much difficulty do you have to reach overhead using your affected arm?**

Unable to perform                  A lot                  Some                  A little                  None

**5. How much difficulty do you have lifting/carrying items using your affected arm?**

Unable to perform                  A lot                  Some                  A little                  None

**6. How much difficulty do you have reaching behind your back using your affected arm (i.e. to put on your waist belt; clasp your bra; to put on your seat belt)?**

Unable to perform                  A lot                  Some                  A little                  None

**7. How much difficulty do you have with bathing and dressing activities?**

Unable to perform                  A lot                  Some                  A little                  None

**8. Please indicate your pain range within the last week giving a score for the lowest and highest on the scale below.**

No pain 0      1      2      3      4      5      6      7      8      9      10 Worst pain ever