PRO SPORT ORTHOPEDICS
EMPOWERING HUMAN PERFORMANCE

NEW SHOULDER PATIENT INTAKE FORM

Full Name: _____ **Date:** _____

What is your chief complaint/reason for the visit?_____

Occupation/Employer:_____

Hand Dominance:_____

Which shoulder would you like to discuss today?(check one) ☐ Right ☐ Left ☐ Bilateral

Are your symptoms: (check one) ☐ New ☐ Recurrent ☐ Chronic

Did your symptoms begin: (select one option) ☐ Insidiously ☐ Suddenly

Where were you when your symptoms first began? (select one option)

☐ Home ☐ Skilled nursing facility ☐ Work ☐ School ☐ The gym ☐ While ☐ traveling
☐ Other:_____

When did your symptoms first occur? (provide a date or the most accurate time frame):_____

Describe what caused your symptoms?_____

_____

_____

How have your symptoms evolved since the onset? (select all that apply)

☐ Intermittent
☐ Constant
☐ Mildly progressive
☐ Moderately progressive
☐ Severely progressive
☐ Improving gradually
☐ Improving quickly
☐ Improving and have completely resolved

What symptoms are you experiencing? (select all that apply)

☐ Pain with normal daily activities
☐ Night pain
☐ Shoulder instability
☐ Weakness
☐ Hypersensitivity
☐ Numbness (complete absence of sensation)
☐ Pain with overhead lifting
☐ Mechanical sensations with motion
☐ Stiffness
☐ Fatigue
☐ Deficient sensation

If you have had prior dislocations, please answer the following:

Total number of dislocations:_____ Date of most recent dislocation:_____
How was the shoulder first dislocated?_____
How was the shoulder dislocated most recently?_____

How has the shoulder been relocated? (select all that apply)

- ☐ Spontaneously (on its own)
- ☐ Manually reduced at the scene
- ☐ Reduced in an urgent care/ER setting
- ☐ Reduced in an ER with conscious sedation
  - ☐ Can you "pop" you shoulder in an out of the socket?_____
  - ☐ Does your shoulder dislocate when you sleep?_____

If you feel shoulder pain, please describe it (select all that apply):

☐ Shock-like ☐ Aching ☐ Shooting ☐ Dull
☐ Sharp ☐ Throbbing ☐ Deep

How severe is the pain on a scale from 1 (minimal) to 10 (most severe)?_____

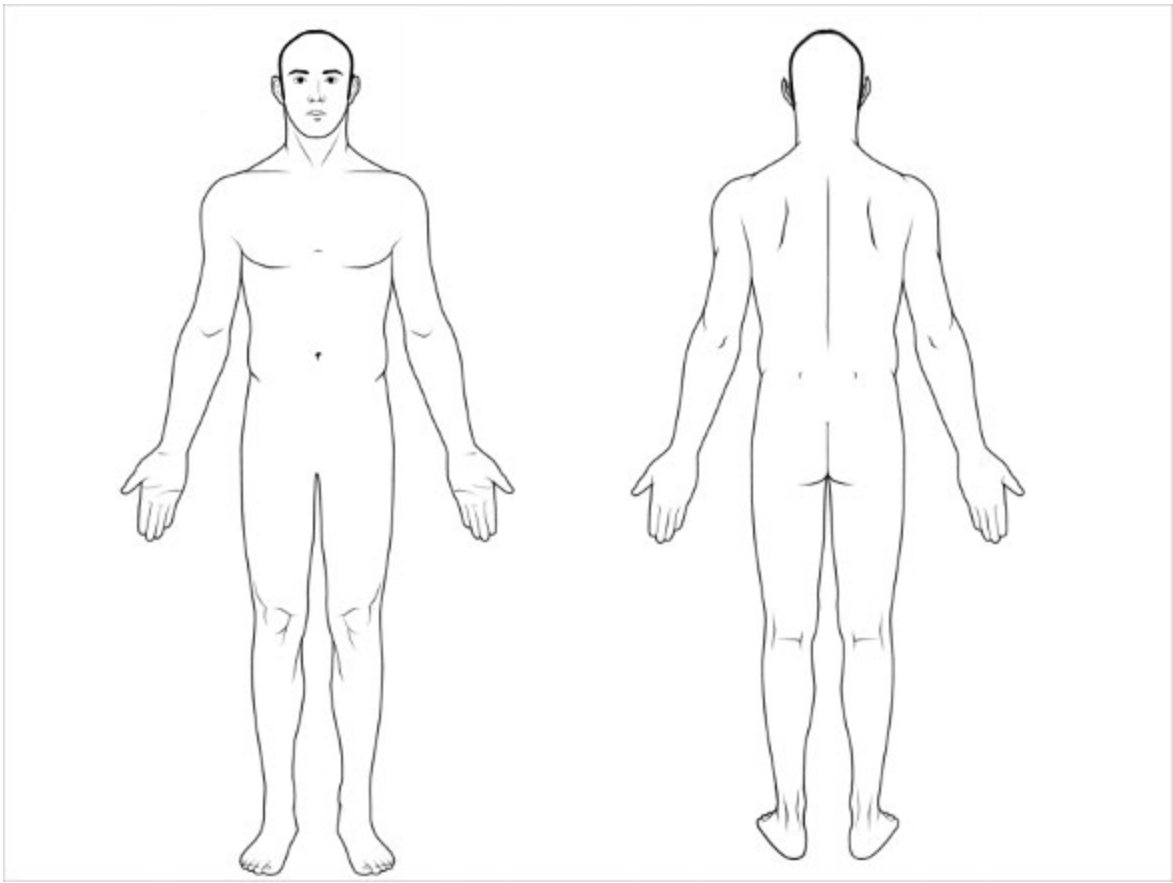
Nature of pain (select all that apply): ☐ Localized ☐ Diffuse

Please use the diagram below to indicate where you feel symptoms.

Use the following key to indicate the different type of symptoms

Stabbing pain: xxxxxxx Burning pain: ///////////////

Deep Ache: 0000000 Pins and Needles: zzzzzzz



Does your shoulder pain radiate? (select all that apply)

☐ No ☐ Pain radiating down the arm, but remaining above the elbow

☐ Pain radiating down the arm, extending below the elbow

What aggravates your symptoms? (select all that apply)

☐ Overhead lifting
☐ Pushing
☐ Pulling
☐ Carrying loads >10 pounds
☐ Exercising
☐ Performing typical job-related tasks
☐ Working around the home
☐ Gardening
☐ Driving
☐ Reaching across
☐ Reaching into the back seat of a vehicle
☐ Coughing/sneezing
☐ Typing
☐ Sleeping
☐ Nothing

What improves your symptoms? (select all that apply)

☐ Rest
☐ Cold therapy
☐ Heat therapy
☐ Physical therapy
☐ Chiropractic treatments
☐ Massage
☐ Stretching
☐ NSAIDs
☐ Narcotics
☐ Non-narcotic pain medications
☐ Corticosteroid injections
☐ Exercise
☐ Nothing
☐ Other:_____

Do you have any neck pain? ☐ Yes ☐ No

Do you have any numbness or tingling in the same extremity? ☐ Yes ☐ No

What is your goal of treatment? (select all that apply)

☐ Decrease pain
☐ Increase strength
☐ Increase range of motion
☐ Increase function
☐ Prevent further decline in function
☐ Maintain employment
☐ Avoid surgery
☐ Return to pre-injury status

What treatments have you attempted? (select all that apply)

☐ None
☐ Rest
☐ Cold therapy
☐ Heat therapy
☐ Over-the-counter pain medications
☐ Anti-inflammatory medications/NSAIDs
☐ Narcotics
☐ Non-narcotic pain medications
☐ Self-directed home exercise program
☐ Other:_____

Have you attempted any provider-directed rehabilitation or therapy program? (select one option)

☐ No ☐ Yes, but for less than 6 weeks within the past 3 months

☐ Yes, for greater than 6 weeks within the past 3 months

If you have had provider-directed rehab:

What type of rehab or therapy was it? (select all that apply)

☐ Physical therapy ☐ Chiropractic sports rehab ☐ Provider-directed home exercise program

What was your response to the rehab? (select one option)

☐ No benefit ☐ Mild benefit, but symptoms remain ☐ Moderate benefit, but symptoms remain

☐ Significant benefit, but symptoms remain ☐ All symptoms have resolved

Have you had any shoulder injections? ☐ No ☐ Yes

If yes, for each injection, please specify:

The date of injection_____

The injection location (into the shoulder joint, into a bursa, other area)_____

The type of injection: (corticosteroid, hyaluronic acid, anti-inflammatory, PRP, bone marrow aspirate concentrate, other, unknown) _____

The maximal percentage of pain (0-100%) that was improved

The duration of the improvement in pain

Date of injection:_____ location:_____ Type:_____ % Pain improved:____ Duration of relief:_____

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Date of injection:_____ location:_____ Type:_____ % Pain improved:____ Duration of relief:_____

What imaging studies of your shoulder have already been obtained?

☐ None

☐ Radiographs within the past 3 months

☐ Radiographs greater than 3 months ago

☐ MRI within the past 3 months

☐ MRI greater than 3 months ago

☐ CT within the past 3 months

☐ CT greater than 3 months ago

☐ Bone scan within the past 3 months

☐ Bone scan greater than 3 months ago

Review Of Systems:

Constitutional:(select all that apply): ☐ Fever ☐ Chills ☐ Night sweats

HENT: ☐ Facial swelling ☐ Nosebleeds

Eyes: ☐ Visual disturbance

Cardiovascular: ☐ Chest pain ☐ Leg swelling

Respiratory: ☐ Shortness of breath ☐ Chest tightness

Gastrointestinal: ☐ Blood in stool ☐ Constipation ☐ Diarrhea

Genitourinary: ☐ Difficulty urinating ☐ Dysuria (pain when urinating) ☐ Flank pain ☐ Blood in urine

Musculoskeletal:

☐ Joint pain ☐ Back pain ☐ Difficulty walking ☐ Joint swelling ☐ Muscle pain ☐ Neck pain

Neurological: ☐ Dizziness ☐ Headaches ☐ Numbness ☐ Limb/muscle weakness

Hematologic: ☐ Bruising ☐ Easy bleeding

Psychological: ☐ Confusion ☐ Nervous/anxious ☐ Self-inflicted injury

Skin: ☐ Changes in skin color ☐ Rashes/lesions ☐ Open wounds

Allergic/Immunologic: ☐ Allergies to new medications/foods/clothing ☐ Hay fever

Endocrine: ☐ Increased urination or thirst ☐ Palpitations ☐ Weight loss or weight gain

Past Medical History:

☐ AIDS/HIV
☐ Alcoholism
☐ Allergy Shots
☐ Anemia
☐ Anorexia
☐ Appendicitis
☐ Arthritis
☐ Asthma
☐ Bleeding Disorder
☐ Breast Lump
☐ Bronchitis
☐ Bulimia
☐ Cancer
☐ Cataracts
☐ Chemical
☐ Dependence
☐ Chicken Pox
☐ Diabetes
☐ DVT/PE/Blood Clots
☐ Emphysema/COPD
☐ Epilepsy
☐ Fractures
☐ Glaucoma
☐ Goiter
☐ Gonorrhea
☐ Gout
☐ Heart Disease
☐ Hepatitis
☐ Hernia
☐ Herniated Disk
☐ Herpes
☐ High Blood Pressure
☐ High Cholesterol
☐ Kidney Disease
☐ Liver Disease
☐ Malignant Hyperthermia
☐ Measles
☐ Migraine/Headache
☐ Miscarriage
☐ Mononucleosis
☐ Multiple Sclerosis
☐ Mumps
☐ Osteoporosis
☐ Pacemaker
☐ Parkinson's Disease
☐ Peripheral Vascular Disease
☐ Pinched Nerve
☐ Pneumonia
☐ Polio
☐ Prostate Problem
☐ Prosthesis
☐ Psychiatric Care
☐ Rheumatoid Arthritis
☐ Rheumatic Fever
☐ Scarlet Fever
☐ S.T.D.
☐ Stroke
☐ Substance Abuse
☐ Suicide Attempt
☐ Thyroid Problems
☐ Tonsillitis
☐ Tuberculosis
☐ Tumors/Growths
☐ Typhoid Fever
☐ Ulcers
☐ Vaginal Infection
☐ Whooping Cough
☐ Other:
☐ No significant medical history

Past Surgical History:

☐ Appendectomy
☐ Biopsy:
☐ Brain Surgery
☐ Breast Surgery
☐ Heart Bypass (CABG)
☐ Gall Bladder Removal
☐ Colon Surgery
☐ Cosmetic Surgery
☐ Eye Surgery
☐ Fracture Surgery
☐ Gastric Bypass/Banding
☐ Hernia Repair
☐ Hip Arthroscopy
☐ Hip Replacement Surgery
☐ Hysterectomy
☐ Knee Arthroscopy
☐ Knee Replacement Surgery
☐ Kidney Stone Surgery (Lithotripsy)
☐ Ovary Removal
☐ Prostate Surgery
☐ Spine Surgery
☐ Tonsil/Adenoid Surgery
☐ Valve Replacement Surgery
☐ Vasectomy
☐ Other:
☐ None

Family Medical History:

Please indicate any major conditions/illnesses that your immediate family members have had:

Relative	Condition and description	Living?	If deceased, at what age?
Mother		☐ Y ☐ N	
Father		☐ Y ☐ N	
Sibling		☐ Y ☐ N	
Other:		☐ Y ☐ N	

Social History:

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Number of children:_____

Alcohol consumption: ☐ None ☐ Yes

Glasses of wine per week:_____ ☐ Cans of beer per week:_____ ☐ Shots of liquor per week:_____

Tobacco use: ☐ None ☐ Yes

Current cigarette use: ____ ppd for ____ years Former cigarette use: ____ ppd for ____ years, quite date: _____

Other nicotine-containing products:_____

Allergies: Please allergies and reactions

Allergies: _____ Reaction: _____

Allergies: _____ Reaction: _____

Allergies: _____ Reaction: _____

Allergies: _____ Reaction: _____

Allergies: _____ Reaction: _____

Allergies: _____ Reaction: _____

Medications:

Medication: _____ Dose: _____ Frequency: _____

Medication: _____ Dose: _____ Frequency: _____

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