

# Patient INTAKE Survey Shoulder

**Staff Only**

Patient Identification Number	Survey Date	MM	DD	YYYY	Payer Source
Please select Patient Proxy, If applicable			Primary Clinician		
Spouse <input type="checkbox"/>			Other Family <input type="checkbox"/>		Caregiver <input type="checkbox"/>
Other <input type="checkbox"/>					
Care Type	Body Part	Multiple Sites <input type="checkbox"/>		Impairment Category	Multiple Categories <input type="checkbox"/>
Patient Name (Last Name, First Name)	Date of Birth			Sex	
	MM	DD	YYYY	Male	Female

We are interested in how you feel about how well you are able to do your usual activities. This information will help us take better care of you. Please answer the questions based on the problem for which you are receiving treatment. If you do not do or have not done this activity, please make your best guess as to which response is most accurate.

Today, How much difficulty do you or would you have...	I Can't Do This	Much Difficulty	Some Difficulty	Little Difficulty	No Difficulty
1. Combing or brushing your hair using your affected arm?					
2. Using your affected arm to place a can of soup (1 lb) on a shelf at shoulder height?					
3. Using your affected arm to pick up and drink out of a full water glass?					
4. Using your affected arm to reach a shelf that is at shoulder height?					
5. Using your affected arm to reach an overhead shelf?					
6. Pushing yourself out of a chair using both arms?					
7. Reaching across to the middle of the table with your affected arm to get a salt shaker while sitting?					
8. Getting a scarf or necktie over your head and around your neck, using both hands?					
9. Putting on deodorant under the arm opposite your affected shoulder?					
10. Pulling a chair out from a table using your affected arm?					

**11. Please indicate the amount of pain you have had in the last 24 hours (Please circle Number):**  
 No Pain \_\_\_\_\_ Pain as bad as it can be  
 0 1 2 3 4 5 6 7 8 9 10

**12. Indicate the number of surgeries for your primary condition** \_\_\_\_0 \_\_\_\_1 \_\_\_\_2 +

**13. How many days ago did this condition begin?**  
 \_\_\_\_0 - 7 \_\_\_\_8 - 14 \_\_\_\_15 - 21 \_\_\_\_22 - 90 \_\_\_\_91 - 6 mo. \_\_\_\_More than 6 mo.

**14. Are you taking prescription medication for this condition?** \_\_\_\_ Yes \_\_\_\_ No

**15. Have you received treatments for this condition before?** \_\_\_\_ Yes \_\_\_\_ No

**16. I should not do physical activities which (might) make my pain worse.**  
 \_\_\_0 - Completely disagree \_\_\_1 \_\_\_2 \_\_\_3 - Unsure \_\_\_4 \_\_\_5 \_\_\_6 - Completely agree

## Patient INTAKE Survey - Shoulder

Patient Identification Number	Survey Date						
	<table style="margin: auto; border-collapse: collapse;"> <tr> <td style="text-align: center; padding: 2px 5px;">MM</td> <td style="text-align: center; padding: 2px 5px;">DD</td> <td style="text-align: center; padding: 2px 5px;">YYYY</td> </tr> <tr> <td style="border: 1px solid black; width: 40px; height: 20px;"></td> <td style="border: 1px solid black; width: 40px; height: 20px;"></td> <td style="border: 1px solid black; width: 60px; height: 20px;"></td> </tr> </table>	MM	DD	YYYY			
MM	DD	YYYY					

**17. How often have you completed at least 20 minutes of exercise such as jogging, cycling, or brisk walking, prior to the onset of your condition?**

\_\_\_\_\_ At least 3 times per week    \_\_\_\_\_ Once or twice a week    \_\_\_\_\_ Seldom or never

**18. What is your present employment status? (Mark ONE response only)**

- \_\_\_\_\_ Employed and presently working full duty at same job
- \_\_\_\_\_ Employed and presently working full duty at different job
- \_\_\_\_\_ Employed and presently working restricted duty at same job
- \_\_\_\_\_ Employed and presently working restricted duty at different job
- \_\_\_\_\_ Employed but presently not working due to my condition
- \_\_\_\_\_ Previously employed and receiving disability benefits for my condition
- \_\_\_\_\_ Unemployed
- \_\_\_\_\_ Retired
- \_\_\_\_\_ Student
- \_\_\_\_\_ Other

**19. Other health problems may affect your treatment. Please check any of the following problems that apply to you:**

<ul style="list-style-type: none"> <li>_____ Arthritis (rheumatoid / osteoarthritis)</li> <li>_____ Osteoporosis</li> <li>_____ Asthma</li> <li>_____ Chronic Obstructive Pulmonary Disease (COPD), acquired respiratory distress syndrome (ARDS) or emphysema</li> <li>_____ Angina</li> <li>_____ Congestive Heart Failure (or heart disease)</li> <li>_____ Heart Attack (Myocardial Infarction)</li> <li>_____ High Blood Pressure</li> <li>_____ Neurological Disease (such as Multiple Sclerosis or Parkinson's)</li> <li>_____ Stroke or TIA</li> <li>_____ Peripheral Vascular Disease</li> <li>_____ Headaches</li> <li>_____ Diabetes Types I and II</li> <li>_____ Gastrointestinal Disease (ulcer, hernia, reflux, bowel, liver, gall bladder)</li> </ul>	<ul style="list-style-type: none"> <li>_____ Visual Impairment (such as cataracts, glaucoma, macular degeneration)</li> <li>_____ Hearing Impairment (very hard of hearing, even with hearing aids)</li> <li>_____ Back Pain (neck pain, low back pain, degenerative disc disease, spinal stenosis)</li> <li>_____ Kidney, Bladder, Prostate or Urination Problems</li> <li>_____ Previous Accidents</li> <li>_____ Allergies</li> <li>_____ Incontinence</li> <li>_____ Anxiety or Panic Disorders</li> <li>_____ Depression</li> <li>_____ Other disorders</li> <li>_____ Hepatitis / AIDS</li> <li>_____ Prior Surgery</li> <li>_____ Prosthesis / Implants</li> <li>_____ Sleep dysfunction</li> <li>_____ Cancer</li> </ul>
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20. Height: \_\_\_\_\_ ft \_\_\_\_\_ in.

21. Weight: \_\_\_\_\_ lbs