PROLIANCE SURGEONS®

OPA ortho™

SHOULDER EVALUATION FORM

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Name_____ Age_____ Date _____

☐ Right Handed / ☐ Left Handed Involved Shoulder ☐ Right ☐ Left ☐ Both – ☐ Right Worse ☐ Left Worse

When did your problem start? _____ Was there an injury? ☐ Yes ☐ No

What happened to shoulder? (i.e. fall directly onto shoulder, landed on outstretched arm,)

_____

Do you have ☐ clicking ☐ catching ☐ loose/unstable shoulder ☐ stiffness/loss of motion ☐ weakness

☐ pain that awakens you from sleep ☐ numbness/tingling down arm ☐ neck pain

Location of pain: ☐ Top ☐ Front ☐ Back ☐ Deep Inside ☐ Down outside of arm

How severe is the pain on average? (none) ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 (extreme)

What makes pain worse? (i.e. arm out to side, throwing)_____

What makes pain better?_____

Have you had ☐ X-ray ☐ MRI ☐ Other test_____ for this condition

Previous shoulder injuries/dates_____

_____

Previous treatment

☐ medications ☐ Ibuprofen/Advil ☐ Naproxen/Aleve ☐ Other_____

☐ injections dates_____

percent improvement_____

☐ physical therapy when_____ ☐ helpful ☐ not helpful

☐ sling

☐ surgery

Previous Surgery Date Surgeon

_____

_____

_____

Sports/recreational activities_____

Level of sport ☐ High School ☐ College ☐ Professional ☐ Other _____

Occupation_____

Current School and Grade Level_____

Goals after treatment for this problem_____

For Baseball Players

Position_____ Do you play year round?_____

How many teams?_____ When last played_____

Average pitch count_____

Which part of throwing cycle causes pain?

☐ Early (Cocking phase) ☐ Middle (Ball coming forward/acceleration) ☐ Late (Ball Release)