Do not write, stamp, punch holes or affix a sticker in this area.

To reproduce, follow the printing instructions. Do not fold this form.

Direction of Feed

Shoulder

Please answer every question

***STAFF:** Handwritten items must be entered **MANUALLY**.*

Marking Instructions

Please use a #2 pencil.

Fill in the complete oval as shown...

PLEASE PRINT PATIENT'S LAST NAME

PLEASE PRINT PATIENT'S FIRST NAME

PATIENT'S DATE OF BIRTH — Month / Day / Year

AGE

AFFECTED SIDE

	left	right	both
shoulder	○	○	○

ONSET OF SYMPTOMS

Which best describes how your symptoms began?

○ gradual onset ○ sudden onset ○ due to an injury

How long ago did the symptoms begin?

○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10 ○ >10

○ days ago ○ weeks ago ○ months ago ○ years ago

If you do not remember when your symptoms began, please describe how long you have been experiencing the symptoms:

Over the last: ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10 ○ 11 ○ 12 ○ 13 ○ 14 ○ 15 ○ 16+

○ weeks ○ months ○ years

TIMING

○ constant ○ intermittent ○ occasional

○ rare ○ daytime ○ nighttime

○ pain causes me to wake up from sleep

other: _____

HOW DID YOUR PROBLEM START?

○ at home ○ at work ○ during athletic activities

○ non-vehicle accident ○ motor vehicle accident ○ no known cause

other: _____

If you have had multiple injuries, please describe: _____

MECHANISM

○ pulling ○ twisting ○ lifting ○ bending

○ direct blow ○ fall ○ sleep position ○ repetitive motion

○ reaching

other: _____

PAIN

Are you currently experiencing pain? ○ yes ○ no

How much pain are you experiencing... **0 = no pain** **10 = intolerable**

NOW: ☺ No Pain ○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10 ☹ Intolerable

AT ITS WORST: ☺ No Pain ○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10 ☹ Intolerable

QUALITY

○ sharp ○ dull ○ aching

○ burning ○ stabbing ○ throbbing

○ stinging

other: _____

ASSOCIATED SIGNS AND SYMPTOMS

○ stiffness ○ weakness ○ locking

○ catching ○ numbness ○ tingling

○ giving way

other: _____

*For technical support, please contact PatientLink at **Support@MyPatientLink.com.***

Direction of Feed

Shoulder

Please answer every question

***STAFF:** Handwritten items must be entered **MANUALLY**.*

PROGRESSION

- ◯ worsening
- ◯ improving
- ◯ resolved
- ◯ unchanged

other: _____

WHAT MAKES YOUR PAIN WORSE?

- ◯ **nothing makes the pain worse**
- ◯ lying down
- ◯ walking
- ◯ standing
- ◯ sitting
- ◯ climbing stairs
- ◯ getting out of a chair
- ◯ bending forward
- ◯ bending backward
- ◯ coughing
- ◯ sneezing

other: _____ _____

WHAT MAKES YOUR PAIN BETTER?

- ◯ **nothing makes the pain better**
- ◯ ice
- ◯ heat
- ◯ rest
- ◯ walking
- ◯ standing
- ◯ sitting
- ◯ lying down
- ◯ using a brace
- ◯ using a splint
- ◯ using crutches
- ◯ elevation
- ◯ stretching
- ◯ prescription medication
- ◯ over-the-counter medication
- ◯ changing activities
- ◯ massage
- ◯ physical therapy
- ◯ injections
- ◯ chiropractor
- ◯ previous surgery
- ◯ medications

other: _____

TREATMENT HISTORY

Have you gone to any other locations for today's problem?

- ◯ **none**
- ◯ Urgent Care
- ◯ Emergency Room
- ◯ Chiropractor
- ◯ Inpatient Evaluation
- ◯ Primary Care Provider
- ◯ Other Ortho Physician
- ◯ Other Physician at this Location

other: _____

Have you had any of the following for today's problem?

- ◯ X-Ray
- ◯ CT Scan
- ◯ MRI

other: _____

WORK HISTORY

Are you currently working?

- ◯ no (If no, when did you last work?): _____
- ◯ yes
- ◯ disabled
- ◯ retired

Are you currently on any work restrictions?

- ◯ no
- ◯ yes (please explain): _____

Occupation: _____ **Employer:** _____

CURRENT SYMPTOMS

Please mark all symptoms you are <u>CURRENTLY</u> experiencing.
Mark all that apply. If no symptoms in a category, please mark "NONE."

GENERAL	◯ trouble sleeping ◯ recent weight loss	◯ fatigue ◯ loss of appetite	◯ **NONE**
CARDIOVASCULAR	◯ chest pain	◯ palpitations	◯ **NONE**
SKIN	◯ frequent rashes ◯ skin ulcers	◯ lumps ◯ non-healing wound	◯ **NONE**
EAR / NOSE / THROAT	◯ hearing loss	◯ hoarseness ◯ trouble swallowing	◯ **NONE**
ENDOCRINE	◯ cold intolerance	◯ heat intolerance	◯ **NONE**
EYES	◯ vision loss	◯ blurred vision ◯ double vision	◯ **NONE**
GASTROINTESTINAL	◯ heartburn ◯ nausea	◯ vomiting ◯ blood in stool	◯ **NONE**
GENITOURINARY	◯ blood in urine	◯ painful urination	◯ **NONE**
HEMATOLOGIC / LYMPHATIC	◯ easy bruising	◯ easy bleeding	◯ **NONE**
NEUROLOGICAL	◯ headaches	◯ dizziness ◯ numbness	◯ **NONE**
PSYCHIATRIC	◯ feeling anxious	◯ feeling depressed	◯ **NONE**
RESPIRATORY	◯ chronic cough	◯ shortness of breath	◯ **NONE**