



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

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

Hospital Number: \_\_\_\_\_

Or Patient Sticker

OXFORD SHOULDER INSTABILITY SCORE

Date: \_\_\_\_\_

SIDE: RIGHT / LEFT

Dominant Arm: RIGHT / LEFT

01. DURING THE LAST SIX MONTHS, HOW MANY TIMES HAS YOUR SHOULDER SLIPPED OUT OF JOINT (OR DISLOCATED)?

Table with 5 columns: NOT AT ALL, 1 OR 2 TIMES IN 6 MONTHS, 1 OR 2 TIMES A MONTH, 1 OR 2 TIMES PER WEEK, MORE THAN 1 OR 2 TIMES PER WEEK

02. DURING THE LAST THREE MONTHS, HAVE YOU HAD ANY TROUBLE (OR WORRY) DRESSING BECAUSE OF YOUR SHOULDER?

Table with 5 columns: NO TROUBLE AT ALL, SLIGHT TROUBLE, MODERATE TROUBLE, EXTREME DIFFICULTY, IMPOSSIBLE TO DO

03. DURING THE LAST THREE MONTHS, HOW WOULD YOU DESCRIBE THE WORST PAIN YOU HAVE HAD FROM YOUR SHOULDER?

Table with 5 columns: NONE, MILD ACHE, MODERATE, SEVERE, UNBEARABLE

04. DURING THE LAST THREE MONTHS, HOW MUCH HAS THE PROBLEM WITH YOUR SHOULDER INTERFERED WITH YOUR USUAL WORK?

Table with 5 columns: NOT AT ALL, A LITTLE BIT, MODERATELY, GREATLY, TOTALLY

05. DURING THE LAST THREE MONTHS, HAVE YOU AVOIDED ANY ACTIVITIES DUE TO WORRY ABOUT YOUR SHOULDER – FEARED THAT IT MIGHT SLIP OUT OF JOINT?

Table with 5 columns: NOT AT ALL, VERY OCCASIONALLY, SOME DAYS, MOST DAYS OR MORE THAN ONE ACTIVITY, EVERY DAY OR MANY ACTIVITIES

06. DURING THE LAST THREE MONTHS, HAS THE PROBLEM WITH YOUR SHOULDER PREVENTED YOU FROM DOING THINGS THAT ARE IMPORTANT TO YOU?

Table with 5 columns: NOT AT ALL, VERY OCCASIONALLY, SOME DAYS, MOST DAYS OR MORE THAN ONE ACTIVITY, EVERY DAY OR MANY ACTIVITIES

07. DURING THE LAST THREE MONTHS, HOW MUCH HAS THE PROBLEM OF YOUR SHOULDER INTERFERED WITH YOUR SOCIAL LIFE?

Table with 5 columns: NOT AT ALL, OCCASIONALLY, SOME DAYS, MOST DAYS, EVERY DAY

08. DURING THE LAST FOUR WEEKS, HOW MUCH HAS THE PROBLEM WITH YOUR SHOULDER INTERFERED WITH YOUR SPORTS OR HOBBIES?

Table with 5 columns: NOT AT ALL, A LITTLE/OCCASIONALLY, SOME OF THE TIME, MOST OF THE TIME, ALL OF THE TIME

09. DURING THE LAST FOUR WEEKS, HOW OFTEN HAS YOUR SHOULDER BEEN 'ON YOUR MIND' – HOW OFTEN HAVE YOU THOUGHT ABOUT IT?

Table with 5 columns: NEVER, ONLY IF SOMEONE ASKS, OCCASIONALLY, SOME DAYS, MOST DAYS, EVERY DAY

10. DURING THE LAST FOUR WEEKS, HOW MUCH HAS THE PROBLEM WITH YOUR SHOULDER INTERFERED WITH YOUR ABILITY TO LIFT HEAVY OBJECTS?

Table with 5 columns: NOT AT ALL, OCCASIONALLY, SOME DAYS, MOST DAYS, EVERY DAY

11. DURING THE LAST FOUR WEEKS, HOW WOULD YOU DESCRIBE THE PAIN YOU USUALLY GET FROM YOUR SHOULDER?

Table with 5 columns: NONE, VERY MILD, MILD, MODERATE, SEVERE

12. DURING THE LAST FOUR WEEKS, HAVE YOU AVOIDED LYING IN CERTAIN POSITIONS, IN BED AT NIGHT, BECAUSE OF YOUR SHOULDER?

Table with 5 columns: NO, ONLY 1 OR 2 NIGHTS, SOME NIGHTS, MOST NIGHTS, EVERY NIGHT