Shoulderdoc.co.uk

CLINICIAN: .....

DIAGNOSIS: .....

PLAN: .....

Name: _____

Date of Birth: _____

Hospital Number: _____

Or Patient Sticker

SHOULDER ASSESSMENT FORM

Date: ..... **SIDE: RIGHT / LEFT** **Dominant Arm: RIGHT / LEFT**

This Questionnaire asks about your Shoulder symptoms and activities. We use this questionnaire to help us better understand your shoulder condition and the problems that it causes for you. It ultimately improves the quality of service we provide to you.

PLEASE COMPLETE THE FORM BY CIRCLING THE MOST APPROPRIATE RESPONSE.

A. PAIN: DO YOU HAVE PAIN IN YOUR SHOULDER DURING **NORMAL** ACTIVITIES?

NO PAIN	**MILD PAIN**	**MODERATE PAIN**	**SEVERE PAIN**

A2. LEVEL OF PAIN

IF **0** MEANS NO PAIN AND **15** MEANS THE WORST PAIN YOU CAN HAVE, **PLEASE CIRCLE THE NUMBER** WHICH DESC RIBES YOUR SHOULDER PAIN WHEN YOU ARE DOING **NORMAL** ACTIVITIES.

0	**1 2 3 4 5**	**6 7 8 9 10**	**11 12 13 14**	**15**
NO	**MILD**	**MODERATE**	**SEVERE**	**UNBEARABLE**

B. FUNCTION

B1. DOES YOUR SHOULDER LIMIT YOUR OCCUPATION OR DAILY LIVING?

NO OR VERY SLIGHTLY	**MODERATE LIMITATION**	**SEVERE LIMITATION**

B2. ARE YOUR LEISURE AND RECREATIONAL ACTIVITIES LIMITED BY YOUR SHOULDER?

NO OR VERY SLIGHTLY	**MODERATE LIMITATION**	**SEVERE LIMITATION**

B3. DOES YOUR SHOULDER DISTURB YOUR NIGHT SLEEP?

NO OR VERY SLIGHTLY	**MODERATE LIMITATION**	**SEVERE LIMITATION**

B4. WHAT LEVEL CAN YOU USE YOUR ARM FOR **REASONABLE PAINLESS** MOVEMENT?

WAIST	**CHEST**	**NECK**	**EAR**	**ABOVE HEAD**

B5. ON A SCALE OF 0 TO 10, WHERE 0 IS NOT SATISFIED AND 10 IS VERY SATISFIED, HOW SATISFIED ARE YOU WITH YOUR SHOULDER? **(Circle the correct number)**

0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

C1. WHAT IS YOUR OCCUPATION?_____

C2. HOW WELL CAN YOU PERFORM YOUR OCCUPATION?

EASILY	**WITH LITTLE DIFFICULTY**	**WITH MODERATE DIFFICULY**	**WITH EXTREME DIFFICULTY**	**NOT AT ALL**

C3. WHAT ARE YOUR TWO MAIN SPORTING/LEISURE ACTIVITIES?

_____

C4. HOW WELL CAN YOU PERFORM THESE ACTIVITIES?

EASILY	**WITH LITTLE DIFFICULTY**	**WITH MODERATE DIFFICULY**	**WITH EXTREME DIFFICULTY**	**NOT AT ALL**

PLEASE COMPLETE THE QUESTIONS BELOW FOR YOUR SHOULDER IN THE PAST MONTH:

O1. HOW WOULD YOU DESCRIBE THE WORST PAIN YOU HAD FROM YOUR SHOULDER **IN THE PAST MONTH**?

UNBEARABLE	**SEVERE**	**MODERATE**	**MILD**	**NO**

O2. HOW WOULD YOU DESCRIBE THE PAIN YOU USUALLY GET FROM YOUR SHOULDER **IN THE PAST MONTH**?

UNBEARABLE	**SEVERE**	**MODERATE**	**MILD**	**NO**

O3. HOW MUCH HAS THE PAIN FROM YOUR SHOULDER INTERFERED WITH YOUR USUAL WORK (INCLUDING HOUSEWORK) **IN THE PAST MONTH**?

TOTALLY	**GREATLY**	**MODERATELY**	**A LITTLE BIT**	**NOT AT ALL**

O4. **IN THE PAST MONTH** HAVE YOU BEEN TROUBLED BY PAIN IN YOUR SHOULDER IN BED AT NIGHT?

EVERY NIGHT	**MOST NIGHTS**	**SOME NIGHTS**	**ONLY 1 OR 2**	**NO NIGHTS**

O5. HAVE YOU HAD ANY TROUBLE DRESSING YOURSELF BECAUSE OF YOUR SHOULDER **IN THE PAST MONTH**?

IMPOSSIBLE TO DO	**EXTREME DIFFICULTY**	**MODERATE TROUBLE**	**VERY LITTLE TROUBLE**	**NO TROUBLE AT ALL**

O6. HAVE YOU HAD ANY TROUBLE GETTING IN AND OUT OF A CAR OR USING PUBLIC TRANSPORT BECAUSE OF YOUR SHOULDER **IN THE PAST MONTH**? (WHICHEVER YOU TEND TO USE)

IMPOSSIBLE TO DO	**EXTREME DIFFICULTY**	**MODERATE TROUBLE**	**VERY LITTLE TROUBLE**	**NO TROUBLE AT ALL**

O7. HAVE YOU BEEN ABLE TO USER A KNIFE AND FORK AT THE SAME TIME, **IN THE PAST MONTH**?

NO. IMPOSSIBLE	**WITH EXTREME DIFFICULTY**	**WITH MODERATE DIFFICULTY**	**WITH LITTLE DIFFICULTY**	**YES, EASILY**

O8. **IN THE PAST MONTH** COULD YOU DO THE HOUSEHOLD SHOPPING ON YOUR OWN?

NO. IMPOSSIBLE	**WITH EXTREME DIFFICULTY**	**WITH MODERATE DIFFICULTY**	**WITH LITTLE DIFFICULTY**	**YES, EASILY**

O9. **IN THE PAST MONTH** COULD YOU CARRY A TRAY CONTAINING A PLATE OF FOOD ACROSS A ROOM?

NO. IMPOSSIBLE	**WITH EXTREME DIFFICULTY**	**WITH MODERATE DIFFICULTY**	**WITH LITTLE DIFFICULTY**	**YES, EASILY**

O10. **IN THE PAST MONTH** COULD YOU HANG YOUR CLOTHES UP IN A WARDROBE, USING THE AFFECTED ARM?

NO. IMPOSSIBLE	**WITH EXTREME DIFFICULTY**	**WITH MODERATE DIFFICULTY**	**WITH LITTLE DIFFICULTY**	**YES, EASILY**

O11. **IN THE PAST MONTH** COULD YOU BRUSH/COMB YOUR HAIR WITH THE AFFECTED ARM?

NO. IMPOSSIBLE	**WITH EXTREME DIFFICULTY**	**WITH MODERATE DIFFICULTY**	**WITH LITTLE DIFFICULTY**	**YES, EASILY**

O12. HAVE YOU BEEN ABLE TO WASH AND DRY YOURSELF UNDER BOTH ARMS **IN THE PAST MONTH**?

NO. IMPOSSIBLE	**WITH EXTREME DIFFICULTY**	**WITH MODERATE DIFFICULTY**	**WITH LITTLE DIFFICULTY**	**YES, EASILY**

THANK YOU FOR COMPLETING THIS ASSESSMENT FORM. PLEASE ALSO COMPLETE THE SATISFACTION SURVEY ON PAGE 3.
IF YOU HAVE SHOULDER DISLOCATIONS OR INSTABILITY PLEASE ALSO COMPLETE PAGE 4.
IF YOU HAVE HAD SURGERY WITH MR FUNK COMPLETE PAGE 5.

SATISFACTION SURVEY FORM

We are always looking at ways of improving the information and the service that we provide. We would be grateful if you could take a few moments to answer the following questions to help us improve the service that we provide.

Was your initial enquiry dealt with in a polite and efficient manner?	**YES/NO**
Was the information that you were given at the time of your initial enquiry helpful and informative?	**YES/NO**
Were the documents that you were sent prior to your initial consultation clear and easy to understand?	**YES/NO**
Were the documents that you were sent from the hospital, prior to your surgery clear and easy to understand?	**YES/NO / Not Applicable**
Were you happy with the following aspects of your visit(s) to see Mr Funk?	
The hospital(s) environment(s):	**YES/NO**
The hospital(s) parking facilities:	**YES/NO**
The members of staff at the hospital(s):	**YES/NO**
The punctuality of your appointment(s):	**YES/NO**
The length of your appointment(s):	**YES/NO**
The information given to you at your appointment(s):	**YES/NO**
Were you given the appropriate information when you needed it?	**YES/NO**
Are you satisfied with the overall service that you received?	**YES/NO**

How would you rate the hospital(s): 1 = Poor - 10 = Excellent

	Poor									**Excellent**
Bridgewater	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Oaklands	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Alexandra	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Wrightington	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

Please use the space below to add any comments or suggestions that you feel would be beneficial in improving the service that we offer.

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If you have shoulder dislocations or Instability, or have had surgery for dislocations or instability, please complete this page also

SHOULDER INSTABILTY FORM

Date: _____ **SIDE: RIGHT / LEFT** **Dominant Arm: RIGHT / LEFT**

O1. DURING THE LAST SIX MONTHS, HOW MANY TIMES HAS YOUR SHOULDER SLIPPED OUT OF JOINT (OR DISLOCATED)?

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

O2. DURING THE LAST THREE MONTHS, HAVE YOU HAD ANY TROUBLE (OR WORRY) DRESSING BECAUSE OF YOUR SHOULDER?

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?

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?

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?

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?

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?

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?

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?

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?

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?

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?

NO	ONLY 1 OR 2 NIGHTS	SOME NIGHTS	MOST NIGHTS	EVERY NIGHT

IF YOU HAVE HAD AN OPERATION UNDER THE CARE OF MR FUNK THEN PLEASE COMPLETE THIS PAGE ….

D. POST-OP QUESTIONS

ONLY COMPLETE THIS SECTION IF YOU HAVE HAD AN OPERATION UNDER THE CARE OF MR FUNK

OPERATION: _____ DATE OF OPERATION: _____

TIME POST-OP: **3 Weeks 6 Weeks 3 Months 6 Months 1 Year 2 Years ___ Years**

D1. HOW DO YOU FEEL **NOW**, FOLLOWING YOUR OPERATION?

MUCH BETTER	BETTER	SAME	WORSE

D1a. WHAT PERCENTAGE IMPROVEMENT HAVE YOU HAD SINCE THE OPERATION?

0	10	20	30	40	50	60	70	80	90	100

D2. HAVE YOU **NOW**:

1. RETURNED TO THE SAME OCCUPATION
2. RETURNED TO THE SAME OCCUPATION BUT WITH DECREASED LEVEL OF ACTIVITY (DUE TO THE SHOULDER)
3. CHANGED OCCUPATION DUE TO THE SHOULDER
4. STOPPED WORKING ALL TOGETHER BECAUSE OF YOUR SHOULDER

D3. IF YOU HAVE CHANGED OCCUPATION WHAT JOB DO YOU DO NOW?

_____

D4. HAVE YOU **NOW**:

1. RETURNED TO THE SAME LEVEL OF ACTIVITY IN THE SAME SPORT
2. RETURNED TO A DECREASED LEVEL OF ACTIVITY IN THE SAME SPORT (BECAUSE OF THE SHOULDER)
3. CHANGED SPORTS BECAUSE OF THE SHOULDER)
4. STOPPED PLAYING SPORTS ALTOGETHER BECAUSE OF THE SHOULDER

D5. IF YOU HAVE CHANGED SPORTS WHAT HAVE YOU CHANGED TO?

_____

G. COMMENTS

THE SPACE BELOW IS FOR ANY FURTHER COMMENTS YOU WOULD LIKE TO MAKE

THANK YOU FOR COMPLETING THIS ASSESSMENT FORM.
THE CLINICIAN WILL COMPLETE THIS PAGE WITH YOU.

E. MOVEMENT

CIRCLE THE APPROPRIATE BOXES (ONE IN EACH COLUMN ONLY):

Forward Flexion (degrees)	Abduction (degrees)	Ext Rotation	In Rotation
0-30	0-30		Thigh
31-60	31-60	Behind head, elbow FWD	Buttock
61-90	61-90	Behind head, elbow back	SI Joint
91-120	91-120	Above head, elbow FWD	Waist
121-150	121-150	Above head, elbow back	T12
> 150	> 150	Full elevation	Betw. Scapulae

F. STRENGTH **AVERAGE = _____pounds**

FINAL DIAGNOSIS: _____

PLAN: _____