

Date: _____



Shoulder Pain Radiation Form


Patient Details Name: _____


Date of Birth: _____ Hospital Number: _____


Sex: M / F


Please draw and shade in the area of your pain on the diagram using the guide below:

(eg. draw an area of crosses where you have stabbing/sharp pain)

 = STABBING and/or SHARP and/or SHOOTING PAIN

 = BURNING PAIN

 = DULL and/or ACHING PAIN

 = NUMBNESS and/or PINS & NEEDLES

Indicate on this line how bad your pain is – at the end of the line means no pain at all, at the right end of the line means worst pain possible

No Pain

Worst Pain Possible

