

**THE CENTER FOR ADVANCED SPORTS MEDICINE  
KNEE AND SHOUDLER**

**SHOULDER INTAKE FORM**

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

Occupation: \_\_\_\_\_ Age: \_\_\_\_\_

Referred by: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_

**CHIEF COMPLAINT:**

- Is your problem in the:                      Right shoulder                      Left shoulder
- What is your dominant hand?              Right hand                      Left hand
- How long have you had this problem? \_\_\_\_\_
- Is your problem getting:      Worse              Better              Staying the same
- Was this the result of an injury?      YES              NO

If yes, please describe how it happened: \_\_\_\_\_  
\_\_\_\_\_

- Is this a worker's compensation injury?      YES              NO

If yes, please answer the following questions. If no, please advance to next heading

1. Job title: \_\_\_\_\_

2. Date of injury: \_\_\_\_\_

3. Are you:      Off work              Modified/light duty              Full duty

4. If you are not working, what date did you last work? \_\_\_\_\_

**SYMPTOMS:**

- If you are experiencing pain, where is it located?  
Top of shoulder                      Down to elbow/wrist                      Front of shoulder  
Up from elbow/wrist                      Back of shoulder                      Neck

- Please rate the intensity of your pain/discomfort. (0 = no pain; 10 = severe pain)

0      1      2      3      4      5      6      7      8      9      10

- Please describe your pain:

|            |          |         |          |
|------------|----------|---------|----------|
| off and on | constant | dull    | sharp    |
| throbbing  | tight    | burning | tingling |

- Is your pain worse at any particular time of the day?

|             |         |       |
|-------------|---------|-------|
| Upon waking | Daytime | Night |
|-------------|---------|-------|

- What activities make your pain/discomfort worse? (Ex: lifting overhead) \_\_\_\_\_  
\_\_\_\_\_

- Do you ever have the following symptoms in your knee?

|             | Yes | No | If yes, please describe |
|-------------|-----|----|-------------------------|
| Stiffness   |     |    | _____                   |
| Numbness    |     |    | _____                   |
| Swelling    |     |    | _____                   |
| Weakness    |     |    | _____                   |
| Instability |     |    | _____                   |
| Other       |     |    | _____                   |

- Has your shoulder ever dislocated?      YES      NO  
If yes, how many times? \_\_\_\_\_      Which shoulder? \_\_\_\_\_

PRIOR TREATMENT:

- Have you tried any of the modalities below?      Symptoms relieved?

|                    | <u>Yes</u> | <u>No</u> | <u>Description</u>    | <u>(Y/N)</u> |
|--------------------|------------|-----------|-----------------------|--------------|
| ○ Medication       |            |           | Names: _____          | _____        |
| ○ Physical therapy |            |           | Length of time: _____ | _____        |
| ○ Injections       |            |           | How many: _____       | _____        |
| ○ Other            |            |           | Describe: _____       | _____        |

MEDICAL HISTORY:

- Do you have a current or past history of the following?

Yes      No      Please describe all "yes" responses.

- Heart problem \_\_\_\_\_
- Lung problem \_\_\_\_\_
- High blood pressure \_\_\_\_\_
- Diabetes \_\_\_\_\_
- Cancer \_\_\_\_\_
- Stomach problems \_\_\_\_\_
- Kidney problems \_\_\_\_\_
- Liver problems \_\_\_\_\_
- Seizures \_\_\_\_\_
- Thyroid problems \_\_\_\_\_
- Other \_\_\_\_\_

- Please list all medications you are currently taking with dosage and frequency:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- Do you have any allergies to medication?      YES      NO      If yes, please list:

\_\_\_\_\_

- Please list past surgeries and hospitalizations:

\_\_\_\_\_  
\_\_\_\_\_

- Do you drink alcohol?      YES      NO      If yes, how much per week? \_\_\_\_\_
- Do you smoke?      YES      NO      If yes, how much per day? \_\_\_\_\_  
How long have you smoked? \_\_\_\_\_
- Do you use a special diet?      YES      NO      If yes, describe: \_\_\_\_\_
- Do you exercise?      YES      NO      If yes, describe: \_\_\_\_\_
- Sports/Hobbies: \_\_\_\_\_
- How tall are you? \_\_\_\_\_      How much do you weigh? \_\_\_\_\_