THE CENTER FOR ADVANCED SPORTS MEDICINE
KNEE AND SHOULDER

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?

	Yes	No	Description	(Y/N)
○ Medication	☐	☐	Names:_____	_____
○ Physical therapy	☐	☐	Length of time:_____	_____
○ Injections	☐	☐	How many:_____	_____
○ Other	☐	☐	Describe:_____	_____

MEDICAL HISTORY:

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

	Yes	No	Please describe all "yes" responses.
o Heart problem	☐	☐	_____
o Lung problem	☐	☐	_____
o High blood pressure	☐	☐	_____
o Diabetes	☐	☐	_____
o Cancer	☐	☐	_____
o Stomach problems	☐	☐	_____
o Kidney problems	☐	☐	_____
o Liver problems	☐	☐	_____
o Seizures	☐	☐	_____
o Thyroid problems	☐	☐	_____
o 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?_____