



## SHOULDER ASSESSMENT FORM

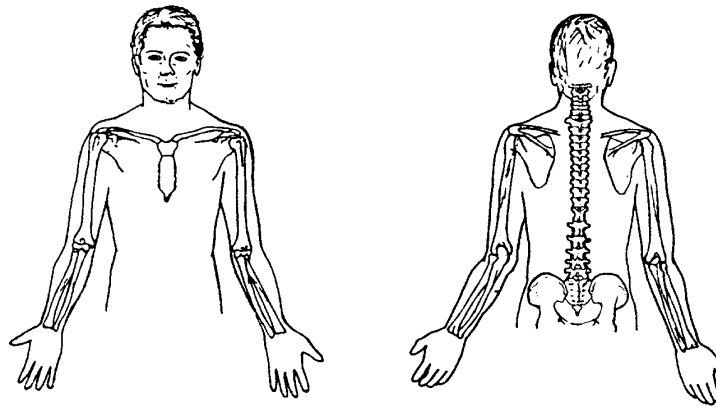
AMERICAN SHOULDER AND ELBOW SURGEONS

Name:		Date
Age:	Hand dominance: R L Ambi	Sex: M F
Diagnosis:		Initial Assess? Y N
Procedure/Date:		Follow-up: M; Y

### PATIENT SELF-EVALUATION

Are you having pain in your shoulder? (circle correct answer)	Yes	No
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Mark where your pain is on this diagram:



Do you have pain in your shoulder at night?	Yes	No
Do you take pain medication (aspirin, Advil, Tylenol etc.)?	Yes	No
Do you take narcotic pain medication (codeine or stronger)?	Yes	No
How many pills do you take each day (average)?	pills	
How bad is your pain today (mark line)?		
0 <span style="display: inline-block; border-bottom: 1px solid black; width: 100px; margin: 0 5px;"></span> 10 No pain at all <span style="float: right;">Pain as bad as it can be</span>		
Does your shoulder feel unstable (as if it is going to dislocate?)	Yes	No
How unstable is your shoulder (mark line)?		
0 <span style="display: inline-block; border-bottom: 1px solid black; width: 100px; margin: 0 5px;"></span> 10 Very stable <span style="float: right;">Very <u>un</u>stable</span>		

Circle the number in the box that indicates your ability to do the following activities:  
 0 = **Unable** to do; 1 = **Very** difficult to do; 2 = **Somewhat** difficult; 3 = **Not** difficult

ACTIVITY		RIGHT ARM	LEFT ARM
1. Put on a coat		0 1 2 3	0 1 2 3
2. Sleep on your painful or affected side		0 1 2 3	0 1 2 3
3. Wash back/do up bra in back		0 1 2 3	0 1 2 3
4. Manage toileting		0 1 2 3	0 1 2 3
5. Comb hair		0 1 2 3	0 1 2 3
6. Reach a high shelf		0 1 2 3	0 1 2 3
7. Lift 10 lbs. above shoulder		0 1 2 3	0 1 2 3
8. Throw a ball overhand		0 1 2 3	0 1 2 3
9. Do usual work - List:		0 1 2 3	0 1 2 3
10. Do usual sport - List:		0 1 2 3	0 1 2 3

## PATIENT DEMOGRAPHIC INSURANCE FORM

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Address: \_\_\_\_\_ Apt # \_\_\_\_\_ City / Town \_\_\_\_\_

State \_\_\_\_\_ Zip code \_\_\_\_\_ \* E-MAIL \_\_\_\_\_

Telephone: \_\_\_\_\_ Work #: \_\_\_\_\_ Cell #: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Sex: Male \_\_\_ Female \_\_\_ Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Marital Status: Single \_\_\_ Married \_\_\_ Separated \_\_\_ Divorced \_\_\_

Employer: \_\_\_\_\_

Primary Insurance Carrier: \_\_\_\_\_

Identification Number: \_\_\_\_\_

Name of Insured/Relation: \_\_\_\_\_ SS# \_\_\_\_\_ DOB \_\_\_\_\_

Secondary Insurance Carrier: \_\_\_\_\_ Identification Number: \_\_\_\_\_

Name of Insured/Relation: \_\_\_\_\_ SS# \_\_\_\_\_ DOB \_\_\_\_\_

Insured Employer: \_\_\_\_\_ Work Number: \_\_\_\_\_

Referral Source: MD: \_\_\_ Relative/Friend: \_\_\_ Yellow Pages: \_\_\_ Other: \_\_\_\_\_

Referring Physician \_\_\_\_\_ Office # \_\_\_\_\_

Physician Address: \_\_\_\_\_

Pharmacy: \_\_\_\_\_ Pharmacy Telephone #: \_\_\_\_\_

Pharmacy Address: \_\_\_\_\_

In care of emergency notify: \_\_\_\_\_ Telephone: \_\_\_\_\_

Relationship: \_\_\_\_\_

### PLEASE DATE AND SIGN BELOW

The provider may release to governmental agencies, insurance carriers or their designated agents or the legal or financial departments representing me or the provider, all information needed to substantiate payment for my medical care and permit representatives thereof to examine and make copies of all records relating to such care and treatment.

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

I hereby assign, transfer, and set over to the above mentioned physician monies and/or benefits to which I may be entitled from governmental agencies, insurance carriers or others who are financially liable for my hospitalization and medical care to cover the costs of the treatment rendered to myself or my dependent, during this hospitalization.

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