Shoulder/Elbow Symptom Questionnaire

This information will help your doctor to understand your problem. Please complete this form as completely as possible. If you have any questions, do not hesitate to ask your doctor.

Name:________________________________ Social Security #__________________________

Today's Date:__________________________ Date of Birth:_____________________________

Please check One: Right Shoulder/Elbow Left Shoulder/Elbow Both Shoulders/Elbows (If both, is one worse than the other? (Which one? __________________)

Is this a work injury?: Yes No

When did your symptoms begin? ____

How did they begin? ____

Are your symptoms: Improving? Worsening? Staying the same?
Please describe your symptoms:

Rate your discomfort level (Circle one): *Minimal* **1 2 3 4 5 6 7 8 9 10** *Severe*

Where does it hurt: (Check all that apply): back of shoulder front of shoulder side of shoulder front of elbow inside of elbow outside of elbow back of elbow other: _______________________________

How would you describe your pain? (Check all that apply): sharp dull grinding throbbing tingling intermittent constant burning other:______________________________

Do you have any other associated symptoms? (Check all that apply):
stiffness (where?_______________)
numbness (where?_______________)
swelling (where?_______________)
snapping/catching (where?______________)
weakness (where?_______________)

When are symptoms worse? (Check all that apply): work with cold after activity night morning during activity with neck movement rising from chair other:____________________

What makes your symptoms better? (Check all that apply): rest therapy brace/bandage heat cold walking aid exercise other:_____________________

Do you have pain in other joints? No Yes (Where?_________________________________)
Have you had other tests? No Yes
(Describe:__________________________________)
Have you had previous treatment? No Yes (Describe:________________________________)