Upper Extremity Symptom and Pain Questionnaire

Last Name: _____ First Name: _____ Middle Initial: _____

Date of Birth: _____ Age: _____ Occupation: _____

Reason for visit: _____

Which side: ☐ Right ☐ Left ☐ Both Approximate date of onset: _____

Please indicate which apply: ☐ Sports injury ☐ Work injury ☐ Motor vehicle accident

☐Other (please describe): _____

Describe how you injured your shoulder and/or upper extremity: _____

Are you: ☐ Right handed ☐ Left handed

Rate your pain discomfort (circle one): None 1 2 3 4 5 6 7 8 9 10 Severe

Major complaint: ☐ Pain ☐ Swelling ☐ Slipping out ☐ Locking ☐ Loss of motion ☐ Grinding ☐ Buckling ☐ Instability ☐ Popping

☐ Other _____

Pain is: ☐ Constant ☐ Frequent ☐ Occasional ☐ Sharp ☐ Throbbing ☐ Burning ☐ Electric shot ☒ Nothing

Location of pain: ☐ Front ☐ Back ☐ Side ☐ Chest ☐ Up into the neck ☐ Down the Arm

☐Other (please describe): _____

Pain associated with: ☐ Reaching ☐ Sleeping ☐ Throwing ☐ Overhead activity

☐ Other (please describe): _____

Pain relieved by: ☐ Rest ☐ Activity ☐ Heat ☐ Ice ☐ Other (please describe): _____

☐ Medication (if so, which): _____

Distance you can walk without pain: ☐ Unlimited ☐ Short distances (how many blocks?): _____

☐ How many aisles in supermarket? _____ ☐ House bound

Treatment to date (check all that apply):

☐ Medication (list): _____
☐ Cortisone injection
☐ MRI/X-ray (when & where): _____
☐ Physical therapy (if so how long & what result): _____
☐ Surgery (please describe): _____ Surgeon: _____ Date: _____
☐Other: _____

Are you experiencing numbness in the arm? ☐ No ☐ Yes

Can you dislocate your shoulder on your own? ☐ No ☐ Yes

Patient signature: _____ **Date:** _____