

SHOULDER EVALUATION FORM

E. Edward Khalfayan, M.D.

drkhalfayan.com

Name _____ Age _____ Date _____
____Right Handed / ____Left Handed Involved Shoulder ____Right ____Left ____Both – ____Right Worse ____Left Worse

When did your problem start? _____ Was there an injury? ____Yes ____No
What happened to shoulder? (i.e. fall directly onto shoulder, landed on outstretched arm,)

Do you have ____clicking ____catching ____loose/unstable shoulder ____stiffness/loss of motion ____weakness
____pain that awakens you from sleep ____numbness/tingling down arm ____neck pain

Location of pain: ____Top ____Front ____Back ____Deep Inside ____Down outside of arm
How severe is the pain on average? (none) 0 1 2 3 4 5 6 7 8 9 10 (extreme)

What makes pain worse? (i.e. arm out to side, throwing) _____
What makes pain better? _____

Have you had ____X-ray ____MRI ____Other test _____ for this condition

Previous shoulder injuries/dates _____

Previous treatment
____medications ____Ibuprofen/Advil ____Naproxen/Aleve ____Other _____
____injections dates _____
 percent improvement _____
____physical therapy when _____ ____helpful ____not helpful
____sling
____surgery

Previous Surgery	Date	Surgeon
_____	_____	_____
_____	_____	_____
_____	_____	_____

Sports/recreational activities _____
Level of sport ____High School ____College ____Professional ____Other _____
Occupation _____
Current School and Grade Level _____
Goals after treatment for this problem _____

For Baseball Players
Position _____ Do you play year round? _____
How many teams? _____ When last played _____
Average pitch count _____
Which part of throwing cycle causes pain?
____Early (Cocking phase) ____Middle (Ball coming forward/acceleration) ____Late (Ball Release)