



**SHOULDER  
PATIENT INTAKE FORM**

**DIVISION OF SPORTS MEDICINE**

Howard Luks, M.D., Chief  
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Name \_\_\_\_\_ Date \_\_\_\_\_

Age \_\_\_\_\_ Occupation \_\_\_\_\_

1. Who referred you to us? Name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

2. Who is your Internist or Primary Care Physician? Name \_\_\_\_\_

Phone \_\_\_\_\_ Address \_\_\_\_\_

3. Chief complaint or current illness? \_\_\_\_\_

Where do you experience this problem? \_\_\_\_\_

Is this a problem with your:  right shoulder  left shoulder

Are you  right-handed  left-handed

How long have you had this problem? \_\_\_\_\_

Is your problem getting  worse  better  same

Was this the result of an injury?  yes  no

If yes, please describe: \_\_\_\_\_

If yes, is this a workers' compensation injury?  yes  no (if **yes**, please skip to **question 5**)

4. Work-related injury:

Job title: \_\_\_\_\_ How long with this employer? \_\_\_\_\_

Date of injury: \_\_\_\_\_ Are you:  Off work  Modified duty  Full duty

If not full duty now, on which date did you last work full duty: \_\_\_\_\_

5. If pain is one of your complaints, please complete the following. If not, skip to question 6.

a. Is your pain in:  Top of shoulder  Front of shoulder  Back of shoulder  Neck  
 Down to elbow/wrist  Up from elbow/wrist

b. Rate the average intensity of your pain/discomfort. (0= no pain, 10= severe pain)

0  1  2  3  4  5  6  7  8  9  10

c. Describe your pain:

Intermittent  Constant  Dull  Sharp  Throbbing  Tight  Burning  Tingling

6. Timing: Is your problem worse at any particular time of the day?

Morning  Afternoon  Evening  Night  All the time

Does your pain allow you to sleep comfortably?  Yes  No

7. Which activities increase your pain/discomfort? (Example: lifting over head)

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8. Do you ever have any of these additional symptoms?

	YES	NO	DESCRIBE
Stiffness			
Numbness			
Swelling			
Weakness			
Instability			
Other			

9. Has your shoulder ever dislocated??  yes  no

10. Have you tried any of the items below? If so, did they help?

	YES	NO	DESCRIBE	Helped	Didn't help
Medication			Type:		
Physical Therapy			For how long? Date of last visit:		
Injections			Where?		
Other:			Describe:		

10. Please list all medications you currently use with dosage and frequency:

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11. Do you have any allergies?  Yes  No If yes, please list:

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12. Have you ever had problems with any of the following? If yes, please describe.

	YES	NO	DESCRIBE:
Heart problem			
Breathing, lungs			
High blood pressure			
Cancer			
Diabetes			
Arthritis			
Hepatitis, AIDS, TB			
Liver problem			
Polio			
Epilepsy or seizures			
Bowel or colon			
Bladder problem			
Kidney problem			
Balance problem			
Numbness or tingling			
Blackout or fainting			

13. Please list all past surgeries and hospitalizations:

REASON	DATE	PHYSICIAN

14. Have you ever had problems with general anesthesia?  YES  NO

15. Do you drink alcohol?  YES  NO How much weekly? \_\_\_\_\_

16. Do you smoke?  YES  NO How much daily? \_\_\_\_\_ For how long? \_\_\_\_\_

17. Marital Status:  Single  Married  Divorced/Separated  Widowed

18. Do you:

	YES	NO	
Have children?			How many?
Live alone?			If no, with whom?
Have a special diet?			Describe:
Use recreational drugs?			Describe:
Exercise regularly?			How often?

19. Sports or hobbies:

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20. Family history:

	ALIVE	DECEASED	AGE	HEALTH	CAUSE OF DEATH
Father					
Mother					
Sibling					
Sibling					
Sibling					
Sibling					

21. Your height \_\_\_\_\_ Your weight \_\_\_\_\_

*Thank you for your time in completing this information!*

Reviewed by: \_\_\_\_\_, M.D.      Date \_\_\_\_\_