

# Shoulder Survey



**NYU Hospital for Joint Diseases**  
 NYU LANGONE MEDICAL CENTER

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Name: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Last First MI

Gender:  Male  Female Dominant Hand:  Right  Left Problem Shoulder:  Right  Left Job Injury:  Yes  No

Occupation: \_\_\_\_\_ Date last worked: \_\_\_\_/\_\_\_\_/\_\_\_\_ Legal Claim:  Yes  No

How bad is your pain today?

0 1 2 3 4 5 6 7 8 9 10  
 No pain at all Worst pain imaginable

Which word below best describes your pain?

None  Moderate  
 Mild  Severe

Please select the statement that best describes your shoulder:

I have no pain  
 I have slight pain during activity  
 I have increased pain during activities  
 I have moderate/severe pain with activity  
 I have severe pain and need medication

Yes	No		0=unable to do 2=somewhat difficult	1=very difficult to do 3=not difficult		
<input type="checkbox"/>	<input type="checkbox"/>	Is your shoulder comfortable with your arm at rest by your side?				
<input type="checkbox"/>	<input type="checkbox"/>	Does your shoulder allow you to sleep comfortably?			Right arm	Left arm
<input type="checkbox"/>	<input type="checkbox"/>	Can you reach the small of your back to tuck in your shirt?			0 1 2 3	0 1 2 3
<input type="checkbox"/>	<input type="checkbox"/>	Can you place your hand behind your head with the elbow straight out to the side?			0 1 2 3	0 1 2 3
<input type="checkbox"/>	<input type="checkbox"/>	Can you place a coin on a shelf at the level of your shoulder without bending your elbow?			0 1 2 3	0 1 2 3
<input type="checkbox"/>	<input type="checkbox"/>	Can you lift one pound (a full pint container) to the level of your shoulder without bending your elbow?			0 1 2 3	0 1 2 3
<input type="checkbox"/>	<input type="checkbox"/>	Can you lift 8 lbs. (a full gallon container) to the level of your shoulder without bending your elbow?			0 1 2 3	0 1 2 3
<input type="checkbox"/>	<input type="checkbox"/>	Can you carry 20 lbs. at your side with your affected arm?			0 1 2 3	0 1 2 3
<input type="checkbox"/>	<input type="checkbox"/>	Can you toss a ball underhand 10 yards with your affected arm?			0 1 2 3	0 1 2 3
<input type="checkbox"/>	<input type="checkbox"/>	Can you throw a ball overhand 20 yards with your affected arm?			0 1 2 3	0 1 2 3
<input type="checkbox"/>	<input type="checkbox"/>	Can you wash the back of your opposite shoulder with your affected arm?			0 1 2 3	0 1 2 3
<input type="checkbox"/>	<input type="checkbox"/>	Would your shoulder allow you to work full time at your usual job?			0 1 2 3	0 1 2 3

Please select the **ONE** statement that best describes your injured shoulder's function.

- Normal function.** I can do all activities of daily living, work and sports activities that I did before my injury (lifting 30 or more pounds, throwing, tennis, swimming).
- I have **mild limitations** in sports and work. I can throw but limited, can lift 15-20 pounds, able to wash back, comb hair and get dressed.
- I have **moderate limitations** in overhead work, sports and lifting (10 pounds). Unable to throw or serve in tennis. Have difficulty with washing back, combing hair or getting dressed (need help sometimes).
- I have **severe limitations**. Cannot do usual work or lifting. No sports. Need help washing and dressing. Can feed myself and comb hair.
- Complete disability** of arm.

Please rate how your shoulder problem affects your ability to work.

4 Fully able to work  
 3  
 2  
 1  
 0 Unable to work

Please rate how your shoulder problem affects your ability to participate in sports or recreational activities.

4 Fully able to work  
 3  
 2  
 1  
 0 Unable to work

Please choose the highest level you are able to use your hands to perform tasks:

- Can use hands only at waist level
- Can use hands at chest level
- Can use hands at neck level
- Can use hands to the top of my head
- Can use hands at levels over my head

### Shoulder Strength Assessment

Do you rely on your shoulders for work:  Yes  No

How important to you is shoulder strength to your occupation? (please circle one)

Not Important 0 1 2 3 4 5 6 7 8 9 Very Important  
10

To what degree are you limited by loss of strength in your job? (please circle one)

Not Limited 0 1 2 3 4 5 6 7 8 9 Very Limited  
10

To what degree are you limited by loss of strength on a day-to-day basis? (please circle one)

Not Limited 0 1 2 3 4 5 6 7 8 9 Very Limited  
10

Are you actively involved in sports:  Yes  No

If so, which sports are you involved in: \_\_\_\_\_

Do you rely on your shoulders for sports?  Yes  No

How important to you is shoulder strength to your sport? (please circle one)

Not Important 0 1 2 3 4 5 6 7 8 9 Very Important  
10

To what degree are you limited by loss of strength in your sport? (please circle one)

Not Limited 0 1 2 3 4 5 6 7 8 9 Very Limited  
10

If your good shoulder is 100% in strength, what percentage is your injured shoulder?

\_\_\_\_\_ %

Please rate the relative importance of strength improvement following treatment (please circle one)

Not Important 0 1 2 3 4 5 6 7 8 9 Very Important  
10

Please rate "How bad has your pain been on average over the LAST 7 Days?" (please circle one)

No Pain at all 0 1 2 3 4 5 6 7 8 9 Worst Pain Imaginable  
10

Please rate the relative importance of pain relief following treatment (please circle one)

Not Important 0 1 2 3 4 5 6 7 8 9 Very Important  
10

Following treatment of your shoulder condition, which outcome would be more satisfactory to you? (please circle one)

A Strong Shoulder with Mild-to-Moderate Pain

A Weak Shoulder with no Pain

## CURRENT HEALTH ASSESSMENT

In general, would you say your health is:

- Excellent
- Very Good
- Good
- Fair
- Poor

The following items are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?

	Yes, limited a lot	Yes, limited a little	No, not limited at all
Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climbing several flights of stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

Yes No

Accomplished less than you would like

Were limited in the kind of work or other activities

During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of emotional problems (such as feeling anxious or depressed)?

Yes No

Accomplished less than you would like

Didn't do work or other activities as carefully as usual

During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?

- Not at all  Quite a bit
- A little bit  Extremely
- Moderately

These questions are about how you feel and how things have been with you during the last 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling. How much of the time during the last 4 weeks:

	All of the time	Most of the time	A good bit of the time	Some of the time	A little of the time	None of the time
Have you felt calm and peaceful?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did you have a lot of energy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you felt downhearted and blue?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting friends, relatives, etc.)?

- All of the time  Most of the time  Some of the time  A little of the time  None of the time

**Thank you for completing this information!**