*Please download and complete patient registration forms

Shoulder Problem: Please circle those that apply to you

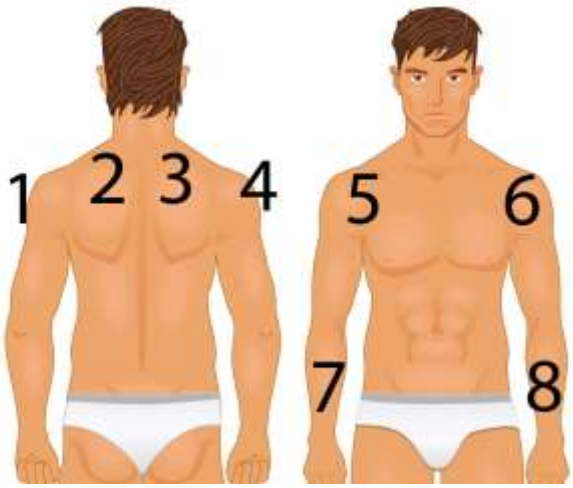
Shoulder: RIGHT LEFT

Problem Onset Gradual / Sudden onset / Result of an injury

Onset Date: _____

Symptoms: Circle all that apply: PAIN WEAKNESS LOSS OF MOTION/ STIFFNESS NUMBNESS INSTABILITY

Location of PAIN: Please circle numbers. In addition, you may draw on the diagram.



History:

Pain, weakness, numbness, range of motion, previous injuries: Tell what is going on in your own words:

Prior studies: Check studies you have had

PLEASE BRING REPORTS AND DISC of images with you to your appointment:

	Xray
	MRI
	CT scan
	Nerve tests
	OTHER TESTS:

Prior Problems: Check those that apply:

	Neck problems: Neck surgery / neck pain
	Carpal tunnel syndrome / carpal tunnel surgery
	Weakness / numbness or pain radiating to hand / fingers
	Abdominal pain
	Angina / heart problems

	Fibromyalgia
	Previous shoulder surgery
	History of RHEUMATOID arthritis PSORIATIC arthritis
	Prior major injury to shoulder (dislocation, rotator cuff tear, fracture)

Prior Treatments:

	Surgery: Date: Operation:	Helped / Did not help
	Physical therapy Number of weeks:	Helped / Did not help
	Injections: Date:	Helped / Did not help
	NSAID (anti inflammatory medication)	Helped / Did not help
	Pain medication	

Other notes for doctor:
