Dirk R. Diefendorf, M.D.
ORTHOPEDIC SURGERY - SPORTS MEDICINE

Initial Shoulder Evaluation

Name_____ Age____ Referring Physician:_____
Occupation_____ Dominant Hand: Right☐ Left☐ Injured Shoulder: Right☐ Left☐
Date of injury/onset of shoulder pain _____ Work Related Injury? Yes☐ No☐
History of shoulder injury/pain_____
_____
_____
Location of shoulder pain_____
_____
Type of pain (Checkmark all that apply) Sharp☐ Dull☐ Burning☐ Stabbing☐ Aching☐ Constant☐
Radiation of pain? Yes☐ No☐ If Yes, describe_____
Pain at Night? Yes☐ No☐ Does the pain awaken you? Yes☐ No☐
Activities/Arm Positions which aggravate the pain _____
_____
Neck pain or stiffness? Yes☐ No☐ Please describe_____
Any numbness/tingling in your arm or hand? Yes☐ No☐ Please describe_____
_____
Do you experience any of the following symptoms? (please checkmark those that apply and describe in detail)
Cracking☐ Popping☐ Catching☐ Locking☐ Swelling☐
Weakness☐ Warmth☐ Stiffness/Loss of Motion☐ Instability☐ Dislocation☐
_____
_____
When is your shoulder pain the worst?_____
What do you do to relieve your shoulder pain?_____
Which medications, if any, have you taken for your shoulder pain? Were they helpful?
_____
Please list all activities, including sports, which are limited by your shoulder pain
_____
_____
Have you had any previous problems with your injured shoulder?_____
_____
Have you had any of the following treatments or tests for your shoulder? (please checkmark and describe in detail)
Surgery☐ Injections☐ Physical Therapy☐ Immobilization☐
MRI scan☐ X-rays☐ Acupuncture☐ Chiropractic☐
Treatment_____
_____
Have you seen any other physicians for your shoulder problem?_____

DOCTOR NOTES:
_____
_____
_____
_____
_____