Northview Wellness Center - Shoulder Pain Clinic

Application for Shoulder Pain Treatment (Please Print Clearly)

Name:		Social Security#:		Date:
Date of Birth:	Age:	Sex: M F	Marital Status M S D W	# of children:
Address:				
City:		State:	Zip:	
Home Phone #:		Cell #:		
E-mail Address:				
Spouse's Name:				
Occupation (Current or Previous)				Retired: Y N
Current or Previous Work	Clerical: Y N	Light Labor: Y N	Moderate Labor: Y N	Heavy Labor: Y N
In Case of Emergency Contact Name		Phone Number:		

TELL US ABOUT YOUR PAST HEALTH:

Y	N	□ Lower Back Pain	Y	N	□ Diabetes (A1C = _____)	Y	N	□ High Cholesterol
Y	N	□ Leg or Foot Pain/Numbness	Y	N	□ Hand Problems	Y	N	□ Shingles
Y	N	□ Prior Spinal Surgeries	Y	N	□ Neuropathy	Y	N	□ Knee Surgery
Y	N	□ Spinal Fractures	Y	N	□ Heart Attack	Y	N	□ Kidney issues or Dialysis
Y	N	□ Spinal Stenosis	Y	N	□ Heart Problems	Y	N	□ Gout
Y	N	□ Spinal Arthritis	Y	N	□ High / Low Blood Pressure	Y	N	□ Hip Surgery
Y	N	□ Sciatica	Y	N	□ Vascular Leg Problems	Y	N	□ Leg Fractures
Y	N	□ Neck Pain	Y	N	□ Vascular Surgery _____	Y	N	□ Joint Replacement
Y	N	□ Herniated Disc	Y	N	□ Stroke	Y	N	□ Foot Surgery

PLEASE LIST ANY MEDICATIONS AND/OR VITAMINS YOU ARE CURRENTLY TAKING, OR ATTACH MED LIST:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

PLEASE LIST BELOW ANY SERIOUS MEDICAL CONDITIONS YOU HAVE HAD:
NAME OF YOUR PRIMARY CARE PHYSICIAN:
MAY WE CONTACT THEM WITH UPDATES REGARDING YOUR TREATMENT? □ YES □ NO
PLEASE LIST BELOW ANY **NECK, SHOULDER, OR FOREARM/HAND SURGERIES** YOU'VE HAD?
HAVE YOU HAD AN **EMG** PERFORMED ON YOUR HAND/ARMS? □ NO □ YES - WHEN:
DO YOU EXERCISE REGULARLY? □ NO □ YES - WHAT:
ARE YOUR SYMPTOMS **WORSE AT NIGHT**? □ NO □ YES – AROUND WHAT TIME?

WHAT KIND OF PROBLEM(S) ARE YOU HAVING:?
ON A SCALE, HOW WOULD YOU RATE YOUR SYMPTOMS (10 is the worst) 1 2 3 4 5 6 7 8 9 10
WHEN DID THIS BEGIN:
WHAT MAKES IT BETTER:
WHAT MAKES IT WORSE:

HOW WOULD YOU DESCRIBE YOUR SYMPTOMS? (Circle any that apply)	Stabbing-Sharp	Electric Shocks	Cold	Tingling	Pins + Needles	Dead Feeling	Throbbing
	Burning	Stings	Ache	Numbness	Swelling	Tiredness	Cramping

WHAT DO <u>YOU THINK</u> IS CAUSING YOUR PROBLEM:

IS THIS CONDITION INTERFERING WITH ANY OF THE FOLLOWING: (Circle any that apply)						
WORK	**SLEEP**	**DAILY ROUTINE**	**CHORES**	**LIFTING**	**REACHING**	**SHOPPING**

<u>How would you describe your average shoulder pain over the past week?</u>

No pain **Worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

<u>Please indicate what you consider to be an acceptable level of pain after completion of the treatment, if you have to accept some pain?</u>

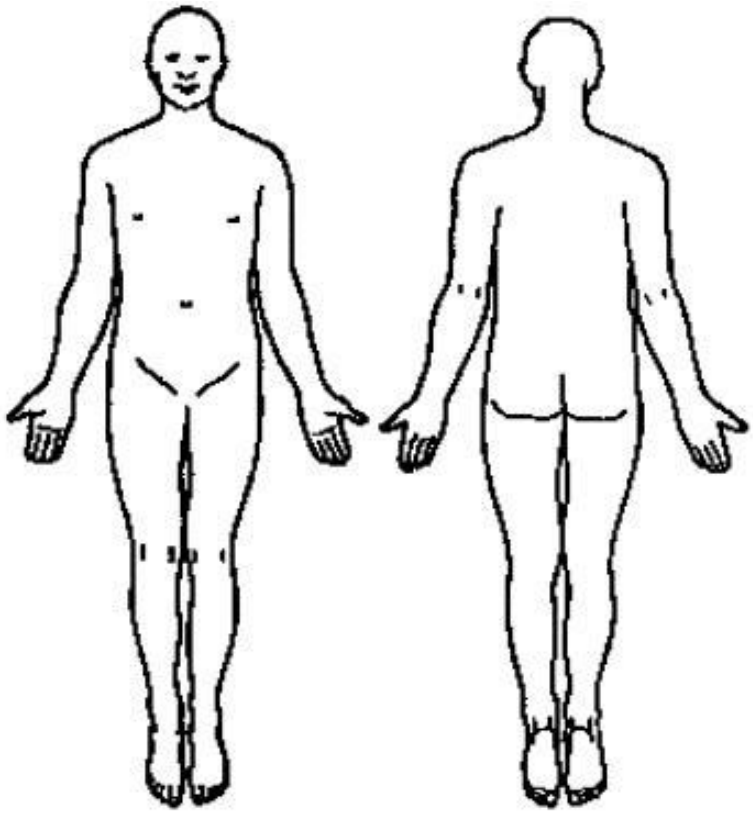
No pain **Worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

Please indicate on these drawings the body area(s) where you are currently experiencing symptoms:

Use the Following Colors:

Pain= Blue
Numbness/Tingling= Yellow
Stiffness= Green



Which of the following is **true** for your condition: (check one of the following)?		
____ It's getting better on its own	____ It's staying the same	____ It's getting worst as time goes by

List any daytime activities (you **used to be able to do** when you were feeling better) that are now limited:

List the three main "health goals" that you would like to accomplish:
1)
2)
3)

A. I hereby authorize release of any medical information necessary to evaluate my case or process any future claims.
B. I authorize payment of any medical benefits from third parties for any future charges submitted to be paid directly to this office.

We invite you to discuss with us any questions regarding our services and or fees. The best health services are based on a friendly, mutual understanding between the provider and patient.

I understand the above information and guarantee this form was completed correctly to the best of my knowledge. I understand it is my responsibility to inform this office of any changes in my medical or insurance status.

Signature _____ Date _____

HOW DID YOU HEAR ABOUT OUR OFFICE?

_____

Pain Scale Questionnaire

These questions ask about limitations to your walking due to knee pain during the past 2 weeks. For each statement please circle the one number that best describes your degree of limitation. Please check you have circled one number for each question. Please hand this to the doctor at the start of your consultation.

In the past 2 weeks, how much has your shoulder pain…	Not at all	A little	Moderately	Quite a bit	Extremely
Limited your ability to lift?	1	2	3	4	5
Limited your ability to grab?	1	2	3	4	5
Limited your ability to push or pull?	1	2	3	4	5
Interfered with completion of daily routine?	1	2	3	4	5
Limited your sleep when using arm during the day?	1	2	3	4	5
Limited time you are able to work?	1	2	3	4	5
Increased the need to have assistance?	1	2	3	4	5
Made it necessary for you to stop or rest while performing household chores or outdoor work?	1	2	3	4	5
Made it necessary for you to use pain medications (e.g. OTC or prescription pain killers)?	1	2	3	4	5
Forced you to alter your plans for the day?	1	2	3	4	5
Affected how smoothly you move your arm?	1	2	3	4	5
Made it difficult for you to concentrate?	1	2	3	4	5

Thank you for completing this questionnaire

WALKING SCALE DISABILITY SCORE: < NORMAL, 13-27 MILD, 28-45 MODERATE, >63 SEVERE DISABILITY

Shoulder Pain Program Qualification Questionnaire

(Please answer ALL the following questions by circling one answer per question.) Thank you for completing this questionnaire. Please return to the front desk.

1. Do you experience shoulder pain? Right / Left / Both
2. Do you experience shoulder pain at rest? Yes / No
3. Do you have shoulder osteoarthritis confirmed by imaging (x-ray/MRI)? Yes / No / Unsure
4. Has your shoulder pain interfered with activities (such as reaching, grabbing, lifting, pushing or pulling) for at least six months? Yes / No
5. Do you have morning shoulder stiffness lasting 30 minutes or less? Yes / No
6. Do you experience a grinding sensation with shoulder movement? Yes / No
7. Have you tried pain and/or anti-inflammatory medications (i.e.: Tylenol, Aspirin, Advil, or capsaicin cream) for at least three months without gaining long-term relief? Yes / No
8. Have you attempted physical therapy to the affected shoulder or participated in a personal exercise program without long-term relief? Yes / No
9. Have you consulted with an orthopedic surgeon regarding your shoulder pain? Yes / No
10. Have you used a shoulder brace without long-term relief? Yes / No
11. Has your doctor ever drained excess fluid from the affected shoulder(s)? Yes / No
12. Have you tried steroid/cortisone injection(s) to the shoulder without long-term relief? Yes / No