

**SHOULDER ASSESSMENT FORM**  
AMERICAN SHOULDER AND ELBOW SURGEONS

Subject ID: _____	Subject Initials: _____	Date: _____
Side: R L	Device: RSP TSA Hemi	DOS:
Side: R L	Device: RSP TSA Hemi	DOS:

**Circle** the number in the box that indicates your ability to do the following activities:  
**0 = Unable to do    1 = Very Difficult    2 = Somewhat Difficult    3 = Normal**

ACTIVITY	LEFT ARM	RIGHT ARM
1. Put on a coat	0 1 2 3	0 1 2 3
2. Sleep on your painful or affected side	0 1 2 3	0 1 2 3
3. Wash back/do up bra in back	0 1 2 3	0 1 2 3
4. Manage toileting	0 1 2 3	0 1 2 3
5. Comb/Wash Hair	0 1 2 3	0 1 2 3
6. Reach a high shelf	0 1 2 3	0 1 2 3
7. Lift 10 lbs. above shoulder	0 1 2 3	0 1 2 3
8. Throw a ball overhand	0 1 2 3	0 1 2 3
9. Do usual work- List:	0 1 2 3	0 1 2 3
10. Do usual sport- List:	0 1 2 3	0 1 2 3

**Pain**

On the following scale of 0 – 10, please **circle** your answer.  
 How bad is your pain today?

0 = No pain at all

10 = Pain as bad as it can be

**0      1      2      3      4      5      6      7      8      9      10**

**Function**

On the following scale of 0 - 10, please **circle** what you consider to be the current overall function of your shoulder.

0 = My shoulder is Useless

10 = My shoulder is Normal

**0      1      2      3      4      5      6      7      8      9      10**

**SIMPLE SHOULDER TEST**

Subject ID: \_\_\_\_\_

Subject Initials: \_\_\_\_\_

Date: \_\_\_\_\_

<b>Answer each question below by checking “Yes” or “No”:</b>	<b>YES</b>	<b>NO</b>
1. Is your shoulder comfortable with your arm at rest by your side?	<input type="checkbox"/>	<input type="checkbox"/>
2. Does your shoulder allow you to sleep comfortably?	<input type="checkbox"/>	<input type="checkbox"/>
3. Can you reach the small of your back to tuck in your shirt?	<input type="checkbox"/>	<input type="checkbox"/>
4. Can you place your hand behind your head with your elbow straight out to the side?	<input type="checkbox"/>	<input type="checkbox"/>
5. Can you place a coin on the shelf at the level of your shoulder without bending your elbow?	<input type="checkbox"/>	<input type="checkbox"/>
6. Can you lift one pound (a full pint container) to the level of your shoulder without bending your elbow?	<input type="checkbox"/>	<input type="checkbox"/>
7. Can you lift eight pounds (a full gallon container) to the level of your shoulder without bending your elbow?	<input type="checkbox"/>	<input type="checkbox"/>
8. Can you carry twenty pounds at your side with the affected extremity?	<input type="checkbox"/>	<input type="checkbox"/>
9. Do you think you can toss a softball under-hand twenty yards with the affected extremity?	<input type="checkbox"/>	<input type="checkbox"/>
10. Do you think you can toss a softball over-hand twenty yards with the affected extremity?	<input type="checkbox"/>	<input type="checkbox"/>
11. Can you wash the back of your opposite shoulder with the affected extremity?	<input type="checkbox"/>	<input type="checkbox"/>
12. Would your shoulder allow you to work full-time at your regular job?	<input type="checkbox"/>	<input type="checkbox"/>

## SF-36 Questionnaire

**Instructions:** Thank you in advance for taking the time to fill this questionnaire out. This questionnaire is about **YOU** and how **YOU** feel your physical health affects other aspects of your life. There are no right or wrong answers. Please read each question carefully, and answer as honestly as you can. Circle the **ONE** response which **YOU** feel represents **YOUR** feelings.

1. In general, would you say your health is:
 

<input type="checkbox"/> Excellent	<input type="checkbox"/> Very Good	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor
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2. Compared to one year ago, how would you rate your health in general now?
 

<input type="checkbox"/> Much better now than one year ago	<input type="checkbox"/> Somewhat better now than one year ago	<input type="checkbox"/> About the same as one year ago	<input type="checkbox"/> Somewhat worse now than one year ago	<input type="checkbox"/> Much worse now than one year ago
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3. 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
a. Vigorous activities, such as running, lifting heavy objects, participating in strenuous sports?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Lifting or carrying groceries?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Climbing several flights of stairs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Climbing one flight of stairs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Bending, kneeling, or stooping?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Walking more than one mile?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Walking several blocks?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Walking one block?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. Bathing or dressing yourself?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
  
4. 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?
 

	All Of The Time	Most Of The Time	Some Of The Time	A Little Of The Time	None Of The Time
a. Cut down the amount of time you spent on work or other activities?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Accomplished less than you would like?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Were limited in the kind of work or other activities?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Had difficulty performing the work or other activities (for example, it took extra effort)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
  
5. 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 any emotional problems (such as feeling depressed or anxious)?
 

	All Of The Time	Most Of The Time	Some Of The Time	A Little Of The Time	None Of The Time
a. Cut down the amount of time you spent on work or other activities?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Accomplished less than you would like?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Did work or other activities less carefully than usual?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

6. During the past 4 weeks, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbors, or groups?

- Not At All       Slightly       Moderately       Quite A Bit       Extremely

7. How much bodily pain have you had during the past 4 weeks?

- None       Very Mild       Mild       Moderate       Severe       Very Severe

8. 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       A Little Bit       Moderately       Quite A Bit       Extremely

9. These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the answer that comes closest to the way you have been feeling:

How much of the time during the past 4 weeks...

	All Of The Time	Most Of The Time	Some Of The Time	A Little Of The Time	None Of The Time
a. Did you feel full of pep?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Have you been very nervous?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Have you felt down in the dumps?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Have you felt calm and peaceful?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Did you have a lot of energy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Have you felt downhearted and blue?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Did you feel worn out?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Have you been happy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Do you feel tired?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

- All Of The Time       Most Of The Time       Some Of The Time       A Little Of The Time       None Of The Time

11. How true or false is each of the following statements for you?

	Definitely True	Mostly True	Don't Know	Mostly False	Definitely False
a. I seem to get sick a little easier than other people.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. I am as healthy as anybody I know.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. I expect my health to get worse.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. My health is excellent.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

# RANGE OF MOTION

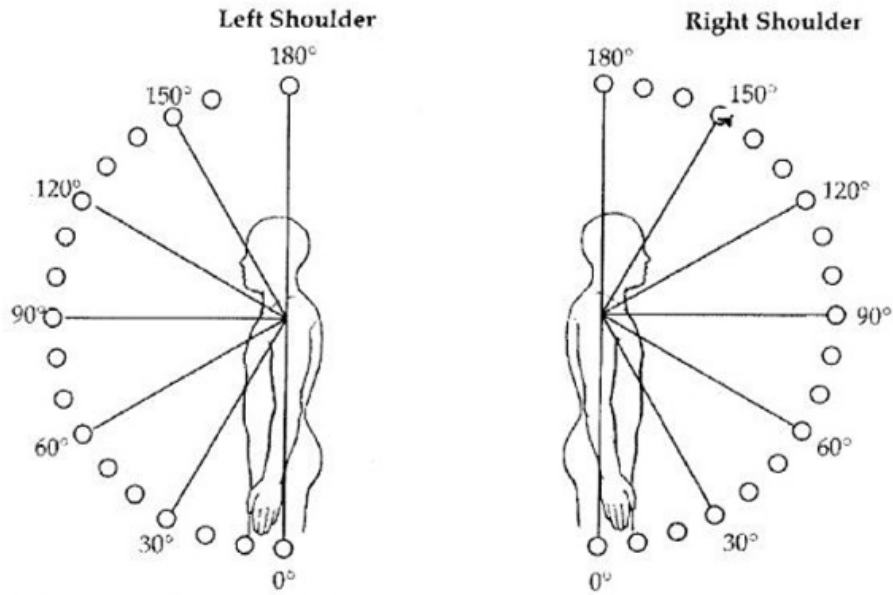
Subject ID: \_\_\_\_\_

Subject Initials: \_\_\_\_\_

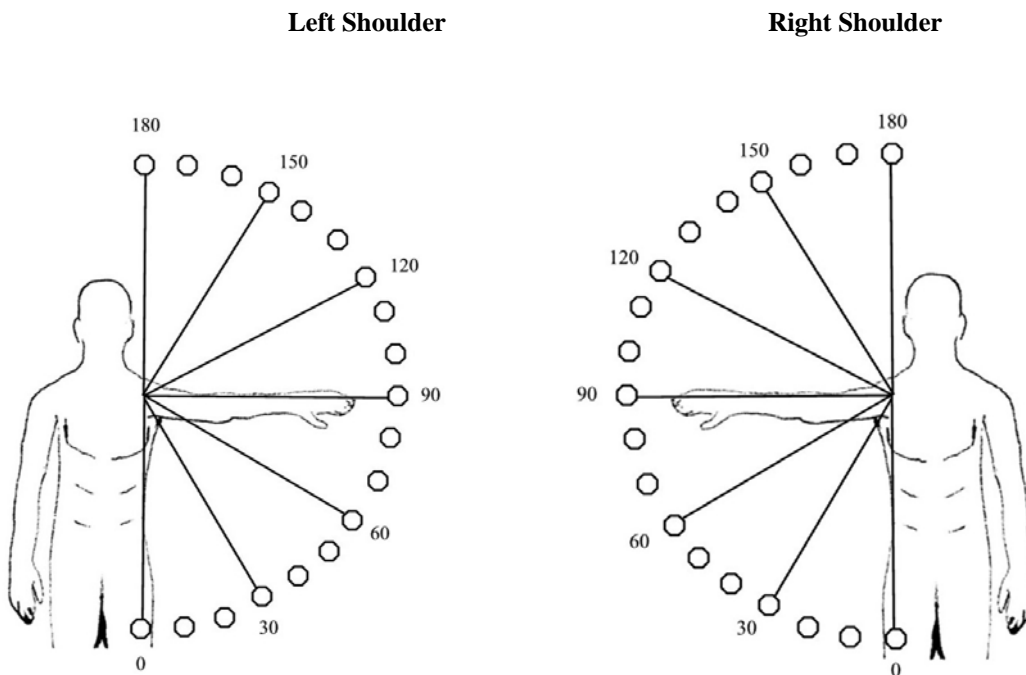
Date: \_\_\_\_\_

Please fill in the circles that indicate how far you can move your arm in the following positions.

Forward Flexion:

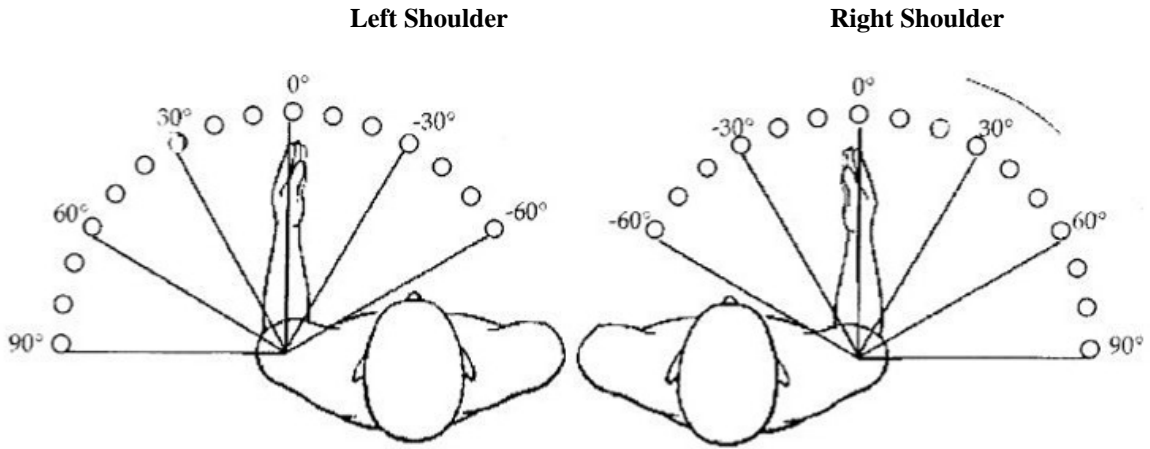


Abduction:

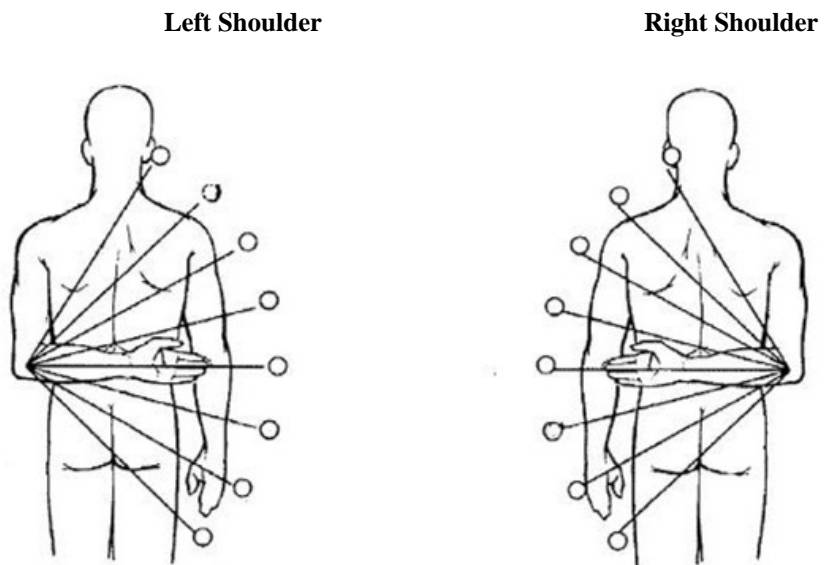


**RANGE OF MOTION**

External Rotation:



Internal Rotation:



**PATIENT SATISFACTION**

Subject ID: _____	Subject Initials: _____	Date: _____
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How satisfied are you with your current outcome?

1 = Unsatisfied 10 = Very Satisfied

**1      2      3      4      5      6      7      8      9      10**

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Based on your outcome, would you still have the same procedure performed?  
(Circle one)

**Yes                  No**

May other patients who may be a candidate for this surgery contact you to help them make their decision regarding surgery? (Circle one)

**Yes                  No**

Comments:

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