SHOULDER ASSESSMENT FORM
AMERICAN SHOULDER AND ELBOW SURGEONS

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

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

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:
   ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

2. Compared to one year ago, how would you rate your health in general now?
   ☐ Much better now than one year ago ☐ Somewhat better now than one year ago ☐ About the same as one year ago ☐ Somewhat worse now than one year ago ☐ Much worse now than one year ago

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?	☐	☐	☐
b. Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf?	☐	☐	☐
c. Lifting or carrying groceries?	☐	☐	☐
d. Climbing several flights of stairs?	☐	☐	☐
e. Climbing one flight of stairs?	☐	☐	☐
f. Bending, kneeling, or stooping?	☐	☐	☐
g. Walking more than one mile?	☐	☐	☐
h. Walking several blocks?	☐	☐	☐
i. Walking one block?	☐	☐	☐
j. Bathing or dressing yourself?	☐	☐	☐

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?	☐	☐	☐	☐	☐
b. Accomplished less than you would like?	☐	☐	☐	☐	☐
c. Were limited in the kind of work or other activities?	☐	☐	☐	☐	☐
d. Had difficulty performing the work or other activities (for example, it took extra effort)?	☐	☐	☐	☐	☐

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?	☐	☐	☐	☐	☐
b. Accomplished less than you would like?	☐	☐	☐	☐	☐
c. Did work or other activities less carefully than usual?	☐	☐	☐	☐	☐

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?	☐	☐	☐	☐	☐
b. Have you been very nervous?	☐	☐	☐	☐	☐
c. Have you felt down in the dumps?	☐	☐	☐	☐	☐
d. Have you felt calm and peaceful?	☐	☐	☐	☐	☐
e. Did you have a lot of energy?	☐	☐	☐	☐	☐
f. Have you felt downhearted and blue?	☐	☐	☐	☐	☐
g. Did you feel worn out?	☐	☐	☐	☐	☐
h. Have you been happy?	☐	☐	☐	☐	☐
i. Do you feel tired?	☐	☐	☐	☐	☐

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?

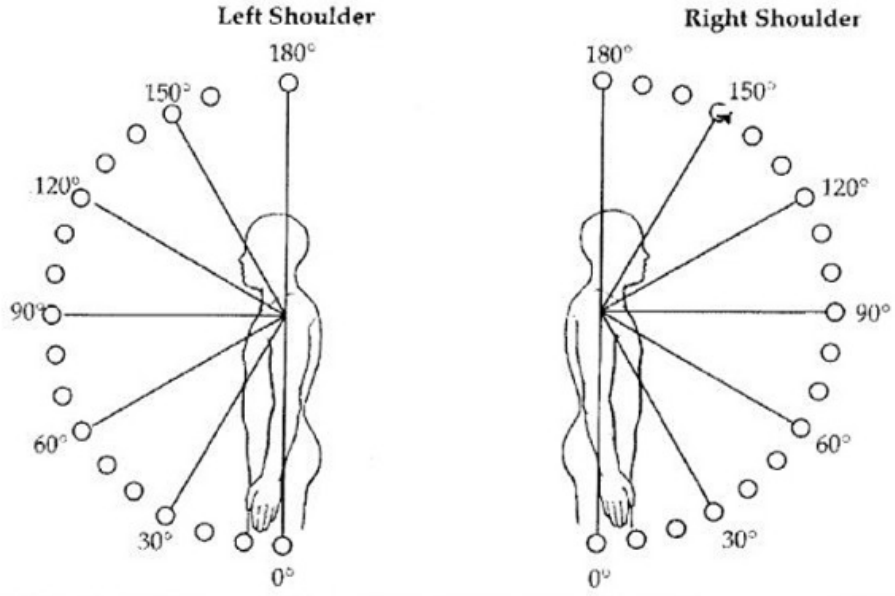
	Definitely True	Mostly True	Don't Know	Mostly False	Definitely False
a. I seem to get sick a little easier than other people.	☐	☐	☐	☐	☐
b. I am as healthy as anybody I know.	☐	☐	☐	☐	☐
c. I expect my health to get worse.	☐	☐	☐	☐	☐
d. My health is excellent.	☐	☐	☐	☐	☐

RANGE OF MOTION

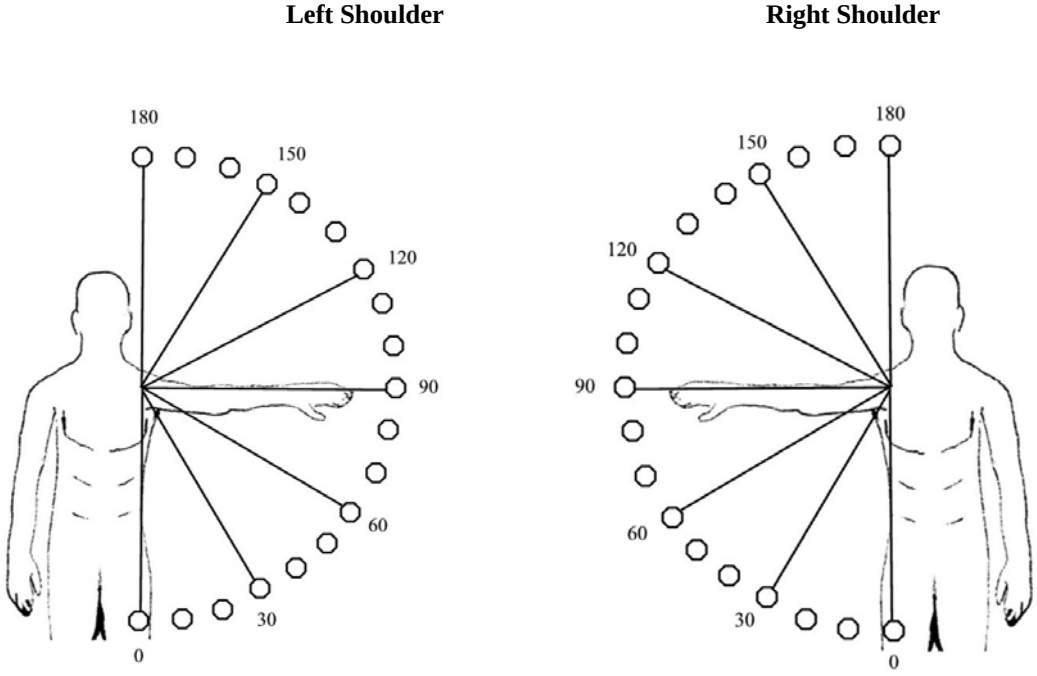
Subject ID: _____	Subject Initials: _____	Date: _____

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

Forward Flexion:

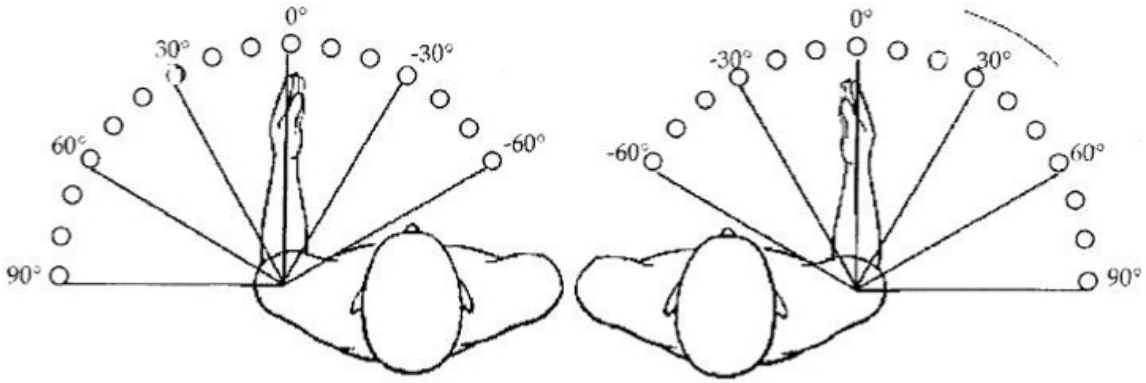


Abduction:



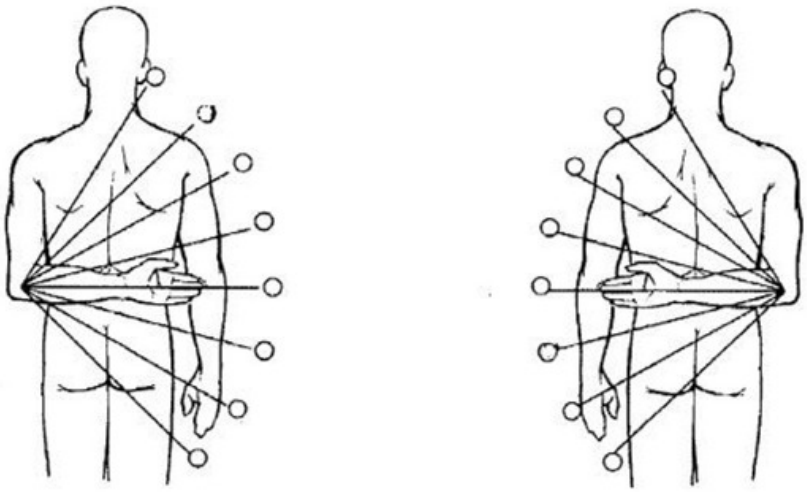
External Rotation:

Left Shoulder **Right Shoulder**



Internal Rotation:

Left Shoulder **Right Shoulder**



PATIENT SATISFACTION

Subject ID: _____	Subject Initials: _____	Date: _____

How satisfied are you with your current outcome?

1 = Unsatisfied 10 = Very Satisfied

1 2 3 4 5 6 7 8 9 10

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:

_____

_____

_____

_____

_____