W. Anthony Frisella, M.D.

St. Peters
Bone & Joint Surgery

GENERAL ORTHOPEDICS • SPINE • SPORTS MEDICINE
FOOT & ANKLE SURGERY • JOINT REPLACEMENT • HAND SURGERY

Simple Shoulder Test

Date:_____ Patient Account #:_____

Patient Name:_____ DOB:_____

Dominant Hand ***(mark only one):*** ____ Right ____Left ____ Ambidextrous

Shoulder Evaluated ***(mark only one):*** ____ Right ____Left

Please answer the following questions:
Your responses will help us provide more individualized care.

	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 with your hand?	_____	_____
4. Can you place your hand behind your head with the elbow straight out to the side?	_____	_____
5. Can you place a coin on a 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?	_____	_____

• 112 Piper Hill Dr. •First Floor, St. Peters, MO 63376 www.spbj.net
636.441.3444 • FAX 636.441.9832

Health Survey

This survey asks for your views about your health. This information will help keep track of how you feel and how well you are able to do your usual activities.

Answer every question by selecting the answer as indicated. If you are unsure about how to answer a question, please give the best answer you can.

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

Excellent	Very Good	Good	Fair	Poor
O	O	O	O	O

2.) The Following questions are about activities you might 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 at all
Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling or playing golf?	O	O	O
Climbing several flights of stairs	O	O	O

3.) During the past 3 weeks, how much of the time 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.) Accomplished less than you would like	O	O	O	O	O
b.) Were limited in the kind of work or other activities	O	O	O	O	O

4.) During the past 4 weeks, how much of the time 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.) Accomplished less than you would like	O	O	O	O	O
b.) Were limited in the kind of work or other activities	O	O	O	O	O

5.) 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
O	O	O	O	O

6.) 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 one answer that comes closest to the way you have been feeling.

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
a.) Have you felt calm and peaceful?	O	O	O	O	O
b.) Did you have a lot of energy?	O	O	O	O	O
c.) Have you felt downhearted and depressed?	O	O	O	O	O

Reviewed By:_____

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

All of the time	Most of the time	Some of the time	A little of the time	None of the time
O	O	O	O	O

American Shoulder & Elbow Surgeons Assessment Form

How bad is your pain today? (circle one)

1 2 3 4 5 6 7 8 9 10
(No Pain at all) (Pain as bad as it can be)

Circle the number in the box that indicates your ability to do the following activities.
0 = Unable to do 1 = Very difficult to do 2 = Somewhat difficult 3 = Not difficult

Activity	Right Arm	Left 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 /latch bra in back	0 1 2 3	0 1 2 3
4. Manage toileting	0 1 2 3	0 1 2 3
5. Comb hair	0 1 2 3	0 1 2 3
6. Reach a high shelf	0 1 2 3	0 1 2 3
7. Lift 10lbs 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 sports – List:_____	0 1 2 3	0 1 2 3

Thank you for completing these questions!

Reviewed By:_____