

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Date: \_\_\_\_\_

Orthopedic History: \_\_\_\_\_ Reason for Visit: \_\_\_\_\_

Is this problem a result of:  MVA  Liability  Work Related  Trauma

Date of Injury: \_\_\_\_/\_\_\_\_/\_\_\_\_ Description of Injury: \_\_\_\_\_

Side:  Right  Left Dominant:  Right-Handed  Left-Handed

History of Present Injury or Complaint: \_\_\_\_\_

How long have you had shoulder pain? \_\_\_\_\_

Do you have pain in your shoulder at night?  Yes  No

Do you take any medications for your shoulder?  Yes  No

What medications do you take for your shoulder? \_\_\_\_\_

Does your shoulder feel unstable (as if it's going to dislocate)?  Yes  No

Do you have pain with daily activities?  Yes  No

Does it hurt to lift your arm above your head?  Yes  No

Do you have pain while throwing?  Yes  No

Have you ever had an injury to your shoulder?  Yes  No

Do you have any numbness or tingling?  Yes  No Where: \_\_\_\_\_

Do you now have or have you ever had:

CONSTITUTIONAL:

Recent weight changes  Yes  No

Recent fever, weakness or fatigue  Yes  No

EYES:

Wear glasses or contact lenses  Yes  No

Glaucoma  Yes  No

Cataracts  Yes  No

Family History  Yes  No Member: \_\_\_\_\_

Family History  Yes  No Member: \_\_\_\_\_

EARS, NOSE, THROAT:

Hearing Problems  Yes  No

Dizziness  Yes  No

Recent cold or sinus pain  Yes  No

Recent sore throat  Yes  No

CARDIOVASCULAR:

Chest pain  Yes  No

Heart attack  Yes  No

Stroke  Yes  No

Heart failure  Yes  No

High blood pressure  Yes  No

Irregular heartbeat  Yes  No

Swelling of hands or feet  Yes  No

Blood clots  Yes  No

High cholesterol  Yes  No

Family History  Yes  No Member: \_\_\_\_\_

Family History  Yes  No Member: \_\_\_\_\_

Family History  Yes  No Member: \_\_\_\_\_

Family History  Yes  No Member: \_\_\_\_\_

Family History  Yes  No Member: \_\_\_\_\_

Family History  Yes  No Member: \_\_\_\_\_

Family History  Yes  No Member: \_\_\_\_\_

Family History  Yes  No Member: \_\_\_\_\_

**RESPIRATORY:**

Asthma  Yes  No Family History  Yes  No Member: \_\_\_\_\_  
 Emphysema  Yes  No Family History  Yes  No Member: \_\_\_\_\_  
 Bronchitis  Yes  No Family History  Yes  No Member: \_\_\_\_\_  
 Pneumonia  Yes  No Family History  Yes  No Member: \_\_\_\_\_

**GASTROINTESTINAL:**

Recent changes in bowel habits  Yes  No  
 Rectal bleeding  Yes  No  
 Liver disease  Yes  No Family History  Yes  No Member: \_\_\_\_\_

**URINARY:**

Problems with urination  Yes  No  
 Urinary tract infections  Yes  No  
 Kidney disease  Yes  No Family History  Yes  No Member: \_\_\_\_\_

**SKIN:**

Recent or current rashes or eruptions  Yes  No Where: \_\_\_\_\_

**NEUROLOGICAL:**

Seizures  Yes  No Family History  Yes  No Member: \_\_\_\_\_  
 Paralysis  Yes  No Where: \_\_\_\_\_  
 Numbness or tingling  Yes  No Where: \_\_\_\_\_  
 Depression/mental illness  Yes  No When: \_\_\_\_\_  
 Anxiety disorders  Yes  No When: \_\_\_\_\_

**ENDOCRINE:**

Thyroid  Yes  No Family History  Yes  No Member: \_\_\_\_\_  
 Diabetes  Yes  No Family History  Yes  No Member: \_\_\_\_\_  
 Treatment:  Diet  Oral Meds  Insulin  
 Medical complications:  Vascular  Renal  Neuropathy  Other: \_\_\_\_\_

**HEMATOLOGIC/LYMPHATIC:**

Anemia  Yes  No Family History  Yes  No Member: \_\_\_\_\_  
 Transfusions  Yes  No Family History  Yes  No Member: \_\_\_\_\_

**CANCER/TUMOR:**

Yes  No Family History  Yes  No Member: \_\_\_\_\_  
 Type: \_\_\_\_\_ Location: \_\_\_\_\_ Treatment: \_\_\_\_\_

**OTHER MEDICAL PROBLEMS:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**HISTORY OF OPERATIONS:**

Yes  No  
 Type: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

DO YOU HAVE ALLERGIES, SENSITIVITIES OR HAVE YOU AN ADVERSE REACTION TO MEDICATIONS?  Yes  No

Please List: \_\_\_\_\_  
 \_\_\_\_\_

CURRENT MEDICATIONS: \_\_\_\_\_

When did you last use aspirin in any form? \_\_\_\_\_

PERSONAL HISTORY:

Cigarettes  Yes  No Amount: \_\_\_\_\_

Alcohol  Yes  No Amount: \_\_\_\_\_

OCCUPATION: \_\_\_\_\_

TESTS DONE RELATED TO PRESENT INJURY OR COMPLAINT:

X-rays  MRI  CT Scan  EMG  Bone Scan  Bone Density  Bloodwork

Tests performed at: \_\_\_\_\_

PRIOR TREATMENT (Best recollection – Check and explain):

Anti-Inflammatories:

Injections (dates & number):

Chiropractic:

Surgery:

Physical Therapy:  Ultrasound  Massage  Strengthening  ROM Stretching  
 Cybex Machines  Cryotherapy  Cortisone Cream  Manipulation  
 Electrical Stimulation

YOUR MEDICAL DOCTOR: Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

YOUR REFERRING DOCTOR: Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

PATIENT SIGNATURE: \_\_\_\_\_

MD SIGNATURE/DATE: \_\_\_\_\_

TO BE FILLED OUT BY THE PHYSICIAN

CERVICAL ROM

- Flexion
- Extension
- Lateral bending
- Lateral rotation

GENERAL

- Deformity
- Contusion
- Atrophy

TENDERNESS

- Anterior
- Posterior
- Lateral

RANGE OF MOTION

- Forward elevation
- Internal rotation
- External rotation

STRENGTH

- Supraspinatus
- Deltoid

INSTABILITY

- Anterior apprehension
- Posterior apprehension
- Inferior apprehension

ROTATOR CUFF

- Impingement sign
- Hawkin's sign
- Yergason test

SLAP

- O'Brien's test

AC JOINT

- Adduction stress test

SEAPULA

- Scapulothoracic crepitus

NEURO EXAM

- C5-T1

WRIST/ELBOW

