Maritzburg Orthopaedic Centre

Practice No.2805928

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Suite D, Block 2, Mediclinic, Payn St. P.M.Burg

Date: ....

Patient's Name: ....

Side: Left / Right.......................................

PLEASE COMPLETE THE FORM BY CIRCLING THE MOST APPROPIATE RESPONSE

PAIN:

Do you have pain in your shoulder during normal activities?

1. No pain 2. Mild pain 3. Moderate pain 4. Severe Pain

LEVEL OF PAIN:

If 0 means no pain and 15 means the worst pain you can have. Please circle the number which describes your shoulder pain when you are doing normal activities.

0	1 2 3 4 5	6 7 8 9 10 11 12 13 14		15
None	Mild	Moderate	Severe	Unbearable

FUNCTION:

Does your shoulder limit your occupation or daily living?

1. No or very slightly 2. Moderate limitation 3. Severe limitation

Are your leisure and recreational activities limited by your shoulder?

1. No or very slightly 2. Moderate limitation 3. Severe limitation

Does your shoulder disturbs your night sleep?

1. No 2. Sometimes 3. Yes

What level can you use your arm for reasonable painless movement?

1. Waist 2. Chest 3. Neck 4. Ear 5. Above Head

On a scale of 0 - 10, where 0 is not satisfied and 10 is very satisfied, how satisfied are you with your shoulder? (Circle the correct number)

0 1 2 3 4 5 6 7 8 9 10

WHAT IS YOUR OCCUPATION ....

How well can you perform your occupation?

1. Easily 2. With little difficulty 3. With moderate difficulty 4. With extreme difficulty 5. Not at all

WHAT ARE YOUR TWO MAIN SPORTING/LEASURE ACTIVITIES?

....

How well can you perform these activities?

1. Easily 2. With little difficulty 3. With moderate difficulty 4. With extreme difficulty 5. Not at all

PAST SURGICAL TREATMENT	OTHER CHRONIC MEDICAL PROBLEMS *(eg HYPER-TENSION, DIABETES ETC)*	CHRONIC MEDICATION BEING TAKEN