New patients and patients arriving for new problems need to arrive 15 minutes before their scheduled appointment time. If you are not early the appointment will be rescheduled.

Dr. Messamore
New Patient Shoulder Questionnaire

Patient Name:_____

MRN:_____ (for office use)

Patient Information

Is someone with you at your appointment today?

Name:_____ Relationship to Patient: _____

Who recommended you to see Dr. Messamore? _____

Chief Complaints (circle all that apply):

Hand Dominance: Right handed / Left handed

Which shoulder is involved? Right / Left / Both Which is worse: Right / Left / Equal

Pain / Limited Motion / Weakness / Popping / Numbness

How long have you had this problem?_____

Did you have an injury? Yes / No If so, when? _____

How did the injury occur? _____

Any other injuries? _____

Symptoms Description:

Pain Is your pain getting: Better / Worse / Same

Where is most of your pain? Front / Back / Outer Side (lateral) / Top / Can't Tell

Intensity: (0=no pain, 10=worst possible pain): At its Best____ At its Worst_____

Character: sharp / stabbing / dull ache / burning / throbbing / other: _____

Duration: constant / intermittent / only with activity / only at night / other: _____

Limited Motion: Motion limited by: pain / strength loss / mechanical block (circle only one)

Work History:

Are you working? Employed / Unemployed / Full-time student / Retired

If NO, are you on disability? NO YES

IF YES, what medical condition causes your disability? _____

Employer: _____

Job Title: _____

Job Requirements: Heavy lifting / Manual labor / Stairs / Kneeling or Squatting / Desk Work

Exacerbating Activity (activities that worsen the symptoms):

Pushing or Pulling / Lifting / Grasping / Writing / Sports Activity

Other: (describe)_____

Relieving Activity (activities that improve the symptoms):

Heat / Ice / Massage / Avoiding Activities / Brace or Sling / Medication

Other: (describe)_____

Does the shoulder affect sleep? NO / YES

If yes, (circle the following): prevents getting to sleep / awakens at night/

Frequency: _____ times a week

Numbness: Do you get any numbness or tingling? YES / NO

When and where: _____

Activities and Hobbies:

Sports: (please list) _____

_____

_____

Other: (please list)_____

_____

_____

Does your complaint today affect these activities? YES / NO

Previous Tests

X-rays: NO / YES Date?_____ Where?_____

MRI: NO / YES Date?_____ Where?_____

Previous Treatment

Medication (including non prescription): NO / YES Name: _____ Helpful? NO / YES
Name: _____ Helpful? NO / YES
Name: _____ Helpful? NO / YES

Occupational/Physical Therapy NO / YES Where: _____Helpful? NO / YES
Length of Time:_____

Chiropractic/Acupuncture NO / YES Where:_____ Helpful? NO / YES

Injection NO / YES Date: _____ By:_____ Helpful? NO / YES
Date: _____ By:_____ Helpful? NO / YES
Date: _____ By:_____ Helpful? NO / YES

Surgery NO / YES Date: _____ By:_____ Helpful? NO / YES
Date: _____ By:_____ Helpful? NO / YES
Date: _____ By:_____ Helpful? NO / YES

Other Current Orthopaedic Conditions

Neck	NO / YES	Who is providing treatment? _____
Shoulder	NO / YES	Who is providing treatment? _____
Wrist/Hand	NO / YES	Who is providing treatment? _____
Back	NO / YES	Who is providing treatment? _____
Hip	NO / YES	Who is providing treatment? _____
Knee	NO / YES	Who is providing treatment? _____
Ankle/Foot	NO / YES	Who is providing treatment? _____

How would you rate your affected joint/region of interest today as a percentage of normal? _____

How would you rate your opposite side today as a percentage of normal? _____
(0% to 100% scale with 100% being normal)

Thank you for choosing Dr. Messamore for your orthopaedic treatment. Please return this form at your appointment.

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