Springfield Orthopaedic & Sports Medicine Institute
30 W. McCreight Avenue
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X-Ray

R L Finger: _____
R L Hand
R L Wrist (AP, Lat, Oblique)
R L Elbow (AP, Lat, Oblique)
R L Shoulder (AP, Grash, AX Scap Y)
R L Hip (with AP Pelvis)
R L Knee (Stand AP, Lat Sunrise)
R L Ankle (AP, Lat, Mortise)
R L Foot (AP, Lat, Oblique)
Other: _____

Shoulder Assessment

Patient's Name: _____ Occupation: _____

Involved shoulder: RIGHT LEFT BOTH Was there an injury? YES NO

Date of Injury _____ Did the injury occur at work? YES NO

Describe what happened to your shoulder:

_____

_____

Primary Care Doctor's Name _____

Who Referred You To Us? _____

Circle problems with your shoulder.

Location: Entire Shoulder Front (anterior) Outer (lateral) Superior Other _____

Quality: Aching Boring Pins/Needles Sharp Sore Stabbing Stinging Throbbing
Other: _____

Severity: Mild Moderate Severe

Rate the Pain: (No pain) 0----1----2----3----4----5----6----7----8----9----10 (Severe pain)

Does the pain affect your sleep? Yes No Do you have: Radiating pain Numbness Tingling

Functional Impairment: Mild Mild-Moderate Moderate Severe/Disabling

Are you currently in pain? Yes No When did it start? Days____ Weeks____ Months____ Years _____

Aggravating Factors: Overhead lifting Repetitive lifting Sports Other _____

Relieving Factors: Cold Heat Massage Other: _____

Previous Treatment: Injections: Yes No Medications _____ OTC _____
Surgeries _____

Joint Symptoms: Grinding Giving Away Instability Locking Looseness Loss of Motion Popping Swelling

Tender to Touch Other _____

** Dr. Thompson and Dr. Galluch are investors in Ohio Valley Medical Center. At times they refer patients to Ohio Valley Medical Center in connection with their care and treatment.*