



Name: _____

Date: ____ / ____ / ____

OVERALL SHOULDER STATUS

Please make a slash on the line that best answers the following questions:

1. How bad is the pain in your shoulder TODAY?

No pain at all |-----| As bad as it can be

2. With respect to your overall shoulder function, how much disability are you having?

Normal |-----| Totally disabled

3. With respect to sporting or recreational activities, how much of a problem is your shoulder?

No problem |-----| Unable to do activities

4. With respect to your work / job, how much of a problem is your shoulder?

No problem |-----| Unable to do work

SPECIFIC FUNCTIONAL STATUS / ACTIVITIES OF DAILY LIVING

Circle the number in the box that indicates your ability to do the following activities. Please use the following scale.

0 = Unable To Do; 1 = Very Difficult; 2 = Somewhat Difficult; 3 = Not Difficult

ACTIVITY	LEFT ARM	RIGHT 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 / do up bra	0 1 2 3	0 1 2 3
4. Manaage 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 5kgs "above" your shoulder	0 1 2 3	0 1 2 3
8. Throw a ball	0 1 2 3	0 1 2 3
9. Do usual work - List:	0 1 2 3	0 1 2 3
10. Do usual sport - List:	0 1 2 3	0 1 2 3
11. Use back pocket	0 1 2 3	0 1 2 3
12. Eat with utensil	0 1 2 3	0 1 2 3
13. Do up seatbelt	0 1 2 3	0 1 2 3
14. Dress	0 1 2 3	0 1 2 3
15. Pulling	0 1 2 3	0 1 2 3
16. Lifting	0 1 2 3	0 1 2 3