William F. Sima, M.D., Inc. ~ Orthopaedic Surgeon

322 Posada Lane, Suite A ~ Templeton, Ca 93465
Phone: 805.434.5555 ~ Fax: 805.434.5502

Welcome,

Thank you for scheduling an appointment with my office. I look forward to evaluating your orthopaedic condition.

As a new patient I need your assistance with the information that will be used to establish your account and medical chart. Attached is paperwork for you to complete PRIOR to your appointment. If a question does not apply to you, write N/A (not applicable) in the appropriate space.

TO AVOID RESCHEDULING PLEASE BRING THE FOLLOWING ITEMS FOR YOUR INITIAL APPOINTMENT:

- PLEASE ARRIVE 15 MINUTES PRIOR TO YOUR SCHEDULED APPOINTMENT
- FILMS **AND** REPORTS (MRI, X-RAY, CT SCANS, ETC.)
- ALL COMPLETED FORMS SENT TO YOU FROM OUR OFFICE
  CURRENT INSURANCE CARDS

MEDICATION REFILL POLICY: I am often out of the office due to my surgical schedule. Please allow 72 hours for refill requests to be processed. If you need a refill on an existing prescription, please call your pharmacy and they will fax a request to our office.

I appreciate your effort and assistance.

Sincerely,

William F. Sima, M.D.

William F. Sima, M.D. Orthopaedic Surgeon
322 Posada Lane, Ste A
Templeton, CA 93465-4003
(805)434-5555

PATIENT INFORMATION (REQUIRED)			
NAME (LAST, FIRST)			
PHYSICAL ADDRESS (ADDR WHERE YOU CURRENTLY RESIDE)		CITY, STATE, ZIP	
MAILING ADDRESS (ADDR WHERE YOU RECEIVE YOUR MAIL)		CITY, STATE - ZIP	
HOME	WORK	CELL	EMAIL(Responsible Party) (I do not wish to receive updates: _____)
SSN	DOB	SEX **M F**	Marital Status **S M D W**
EMPLOYMENT STATUS (CIRCLE ONE) F/T P/T Retired Disabled Other _____	EMPLOYER NAME **OR** SCHOOL (IF STUDENT)		OCCUPATION
PRE RETIREMENT EMPLOYER/OCCUPATION	PRIMARY MD		REFERRING MD

FINANCIALLY RESPONSIBLE PARTY INFORMATION (PERSON **"LEGALLY"** RESPONSIBLE TO PAY)			
NAME	RELATIONSHIP TO PATIENT	SSN	DOB
MAILING ADDRESS		CITY, STATE - ZIP	
HOME	WORK	CELL	

PRIMARY INSURANCE (REQUIRED)				
NAME OF INSURANCE COMPANY	INSURED'S EMPLOYER	OCCUPATION		
NAME OF INSURED	RELATIONSHIP TO PATIENT	SSN	DOB	SEX **M F**
ADDRESS OF INSURED	CITY	STATE	ZIP	

SECONDARY INSURANCE (IF APPLICABLE)				
NAME OF INSURANCE COMPANY	INSURED'S EMPLOYER	OCCUPATION		
NAME OF INSURED	RELATIONSHIP TO PATIENT	SSN	DOB	SEX **M F**

EMERGENCY CONTACT		
NAME	PHONE #	RELATIONSHIP

- I am responsible for payment due at time of service (ie: co-pay, co-ins, ded, non-covered/denied services, and/or cash pay)
- 1.5% per month (18% per yr) interest charge and/or late fee may be added to unpaid balances over 30 days.
- $25.00 non-sufficient funds (NSF) fee will be charged for all returned checks.
- $50.00 may be charged for appointments cancelled or missed without 24 hours notice.
- $15.00 **minimum** charge may be charged for completion of forms.
- $15.00 may be charged for providing inaccurate, outdated, and/or incomplete insurance information that result in additional billing.
- There may be a charge for copying medical records.
- I authorize payment of medical benefits to William F. Sima, MD for services provided.

_____ _____
Patient/Responsible Party Signature Date

P Drive;Sima PIF: 2014

WILLIAM F. SIMA , MD, INC.
322 POSADA LANE, STE. A
TEMPLETON, CA 93465
805-434-5555

PATIENT NAME: _____ **DATE:** _____

Dr. Sima is **required by federal regulations to request the following demographic information:**

ETHNICITY: (PICK ONLY ONE)

___ Hispanic or Latino

___ Not Hispanic or Latino

___ Unknown

___ Unreported/Refused

RACE: (PICK ONLY ONE)

___ American Indian or Alaska Native

___ Asian
- ___ Indian
- ___ Cambodian
- ___ Chinese
- ___ Japanese
- ___ Korean
- ___ Laotian
- ___ Vietnamese

___ Black or African American

___ Native Hawaiian/Other Pacific Islander
- ___ Filipino
- ___ Guamanian
- ___ Samoan

___ White

___ Other Race

___ Unknown

___ Unreported/Refused

PREFERRED LANGUAGE: ____ English ___ Spanish ___ Other: _____

William F. Sima, M.D.
Medicare Coverage Information

DO YOU HAVE MEDICARE COVERAGE ? ☐ **Yes** ☐ **No If "NO" & 65 or over, please**

explain why you do not have Medicare: _____

(FAILURE TO DISCLOSE ALL INSURANCE PLANS CAN CAUSE DENIAL/DELAY OF CLAIM PAYMENT!)

This form must be completed by patients with Medicare coverage (primary or secondary)

Medicare requires that providers determine whether Medicare is the primary or secondary payer for each claim for a Medicare beneficiary. The MSP form is used as a guide during the registration process to help identify other payers which may be primary to Medicare.

- Is the illness/injury due to an automobile accident, liability accident or Workman's Compensation?
  ☐ Yes ☐ No

  If yes, please provide the following information:
  Date of accident; _____/_____/_____
  Nature of accident: ☐ Auto ☐ Workers Compensation ☐ Liability
  Claims address (Auto/Work Comp/Liability): _____
  _____

  Claim Number: _____

- If under age 65, is your Medicare coverage due to disability? ☐ Yes ☐ No

  Are you covered by a large Employer Group Health Plan based on your current employer or your spouse's current employer (20 or more employees)? ☐ Yes ☐ No
  (if yes, Medicare is secondary and primary information must be obtained)

- If 65 and over, are you covered by Employer Group Health Plan based on your own or spouse's current employer? ☐ Yes ☐ No
  (if yes, Medicare is secondary and primary information must be obtained)

SIGNATURE SECTION

Patient Name: _____

Signature (Patient/Responsible Party): _____ Date: _____

Name of Responsible party: _____ Relationship to Patient: _____

William F. Sima, M.D., Inc.

Orthopaedic Surgery, Sports Medicine and Joint Replacement

AUTHORIZATION TO RELEASE / OBTAIN INFORMATION

I hereby authorize William Sima, M.D. to obtain any and all medical records pertinent to my care from any physician, hospital, or other health care professional.

I also hereby authorize William Sima, M.D. to release any medical records belonging to them concerning my care to any physician, hospital, or other health care professional. These may include but not be limited to mental health records protected by Lanterman Pertis Short Act, drug and alcohol abuse records and HIV test results to any except as specifically follows: _____

This authorization is effective now and will be in effect for the time that I am a patient of William Sima, M.D., or until I revoke it in writing.

William Sima, M.D. reserves the right to modify the privacy practices outlined in the notice.

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

A copy of the HIPPA guidelines for the office of William Sima, M.D. was made available to me to read at the front desk. Upon request a copy can be made. I understand that due to these guidelines, medical information will only be discussed with me and those listed below. Medical information may include but is not limited to appointments, prescriptions, test results and chart notes.

NAME: _____ Relationship to Patient: _____ Date of Birth: _____

NAME: _____ Relationship to Patient: _____ Date of Birth: _____

Patient Name: _____ Date of Birth: _____

Signature (Patient/Responsible Party): _____ Date: _____

Name of Responsible party: _____ Relationship to Patient: _____

Documentation of Attempt to Obtain Acknowledgement of Receipt of Notice of Privacy Practices

An attempt was made to obtain an acknowledgement of receipt of the "Notice of Privacy Practices" on _____.
The acknowledgement was not obtained because:

___ The patient was undergoing emergency treatment.
___ The patient declined to sign the acknowledgement.
___ Other _____

Name of Staff Member: _____ Date: _____

Consent to Photograph/Videotape/Film/Interview Individuals

I give William Sima, M.D., Inc. permission to photograph, videotape, film and/or interview myself, and to publish said photographs, videotapes, films, written testimonials and/or interviews on the internet, Dr. Sima's web site and all other forms of media. The photographs, videotapes, etc. shall constitute the exclusive property of William Sima, M.D., Inc. and may be reproduced by William Sima, M.D., Inc., without compensation or payment to the individual concerned or any other person. I also hereby release William Sima, M.D., Inc. and his employees from all claims, demands, and liabilities whatsoever in connection with the above.

Patient Name: _____ Signature: _____ Date: _____

Responsible party: _____ Signature: _____ Relationship to Patient: _____

William F. Sima, M.D., Inc.

Orthopaedic Surgery, Sports Medicine and Joint Replacement

ORIGIN of PAIN

(This information is required by all insurance companies)

Under the provisions of the contract with your private insurance for you and your dependent (s), liability may be an exclusion of your policy. So that your private insurance company can determine if they are correct in accepting liability for the services provided for this problem/injury, they will need the following information:

BODY PART FOR THIS VISIT: _____ (Right or Left)

1. **Is your pain/concern due to: (Circle one of the below)**

   A. Gradual onset = skip to #'s 3& 4
   B. Accidental injury =complete #'s 2, 3, & 4

2. **Briefly describe the onset of your current symptoms (include where injury occurred i.e. work, home, etc.):**

_____

_____

3. **Date symptoms started:** _____

4. **Do you think your problem is related to work? YES or NO** (IF YES, ANSWER #5)

5. **Have you filed a workers' comp claim with your employer? YES or NO**
   If "yes"
   A. Have you notified our office? **YES or NO**
      a. If "NO", **immediately** call our office **at 434-5555.**
      b. If "YES", bring a copy of your claim form to your appointment.
   B. Has your claim been denied or put in delay? **YES or NO**
      a. If "YES", bring a copy of your denial/delay letter to your appointment.

I CERTIFY THE ABOVE STATEMENTS TO BE TRUE TO THE BEST OF MY KNOWLEDGE.

Patient Name: _____

Signature (Patient/Responsible Party): _____ Date: _____

Name of Responsible Party: _____ Relationship to Patient: _____

Name: _____ Date: _____

William F. Sima, M.D., Inc.

Orthopedic Surgery, Sports Medicine and Joint Replacement

MEDICAL HISTORY

Previous Tests and Treatments

☐ Circle here if none apply

☐ Physical Therapy	☐ Made it worse	☐ Made it better	☐ No effect
☐ Anti-inflammatories	☐ Made it worse	☐ Made it better	☐ No effect
☐ Narcotic medication	☐ Made it worse	☐ Made it better	☐ No effect
☐ Chiropractic/Manipulation	☐ Made it worse	☐ Made it better	☐ No effect
☐ Epidural steroid injection	☐ Made it worse	☐ Made it better	☐ No effect
☐ Steroid injection	☐ Made it worse	☐ Made it better	☐ No effect

☐ X-rays ☐ CT ☐ MRI

Please describe your current problem_____

_____

_____

Current Medication(s): ☐ Circle here if none Preferred Pharmacy: _____

Name of Medication	Dose	Duration
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you have any ALLERGIES? ☐ Yes ☐ No

1._____ Reaction: _____

2._____ Reaction: _____

3._____ Reaction: _____

Social History (circle all that apply to you)

Drink alcohol? ☐ Never ☐ Social ☐ Mild ☐ Moderate ☐ Heavy

Employment? ☐ Work in the home ☐ Student ☐ Retired ☐ Employed Full Time ☐ Employed Part Time
Occupation _____

Disabled? ☐ Permanent ☐ Temporary ~ Reason for Disability_____

Exercise? ☐ Never ☐ Rarely ☐ Weekly ☐ Daily What type?_____

Marital Status? ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Live alone ☐ Life Partner

Smoking? ☐ No ☐ Yes _____

Quit smoking? ☐ No ☐ Yes When? _____ Previously smoked _____ packs per day for ___ years

Name: _____ Date: _____

Family History

Do any of your grandparents, parents, siblings or children have the following diseases?

		Relationship			Relationship
Anemia	☐Yes ☐No	_____	Hypertension	☐Yes ☐No	_____
Asthma	☐Yes ☐No	_____	Kidney Disease	☐Yes ☐No	_____
Autoimmune disorder	☐Yes ☐No	_____	Liver problems	☐Yes ☐No	_____
Bleeding disorder	☐Yes ☐No	_____	Lung problems	☐Yes ☐No	_____
Cancer type: _____	☐Yes ☐No	_____	Rheumatoid arthritis	☐Yes ☐No	_____
Cardiovascular	☐Yes ☐No	_____	Seizures	☐Yes ☐No	_____
Deep Venous Thrombosis	☐Yes ☐No	_____	Stroke	☐Yes ☐No	_____
Diabetes	☐Yes ☐No	_____	Thyroid disease	☐Yes ☐No	_____

Past Medical History (circle all that apply to you) ☐ CHECK HERE IF NONE APPLY

Dermatologic: lupus / melanoma / skin cancer

Neurological: epilepsy / seizure disorders / stroke

Renal / Urinary: hematuria / kidney problems / incontinence

Endocrine: diabetes / thyroid disorder

Head and Neck: Dentures / migraines / glaucoma

Genetic Background: congenital heart defect / hemophilia / sickle cell

Childhood Illnesses: polio / asthma

Female Reproductive: cancer / tumors

Male Reproductive: BPH / prostate conditions

Gastrointestinal: Crohn's disease / gastritis / GI bleed / irritable bowel syndrome / ulcer

Respiratory: asthma / bronchitis / emphysema / pulmonary embolism / shortness of breath / tuberculosis / COPD

Musculoskeletal: ankylosing spondylarthritis / arthritis conditions / fibromyalgia / osteoporosis / polio / Rheumatoid arthritis

Cardiovascular: cardiac catheterization / cardiac disease / congestive heart failure / deep vein thrombosis / edema / heart valve conditions / myocardial infarction / stroke / hypertension / Atrial fibrillation

Hematologic/lymphatic: anemia / bleeding tendencies / hemophilia / hepatitis

Psychiatric: alcoholism / depression

All Previous Surgeries ☐ CHECK HERE IF NO HISTORY OF PRIOR SURGERY

1. Date_____ Type_____ L/R
2. Date_____ Type_____ L/R
3. Date_____ Type_____ L/R
4. Date_____ Type_____ L/R
5. Date_____ Type_____ L/R
6 .Date_____ Type_____ L/R

Did you have any complications with your surgeries or anesthesia? ☐ No ☐ Yes

Explain if yes _____

Name: _____ Date: _____

Review of Systems (circle all that apply to you) ☐ **CHECK HERE IF NONE APPLY**

Allergic/ Immunologic: Seasonal Allergies

Cardiovascular: Elevated blood pressure / Heart attack / Heart palpations / Pacemaker / Atrial fibrillation / Heart valve replacement

Constitutional Symptoms: Chills / Fever / Nausea

Ears, Nose, Mouth, Throat: Difficulty with hearing / Cough / Difficulty with swallowing / Loss of hearing

Endocrine: Dry skin / Unusual fatigue / Weight change / Thyroid disease

Eyes: Eye or vision problems / Glasses / Loss of vision

Gastrointestinal: Blood in stool / Diarrhea / Hemorrhoids / Stomach ulcers / GERD

Genitourinary: Blood in urine / Painful urination / Incontinence

Hematologic/ Lymphatic: Anemia / Bleeding problems / Bruise easily

Integumentary: Non healing wound / Rash

Musculoskeletal: Back pain / Difficulty getting out of a chair

Neurological: Balance problems / Difficulty walking / Headaches / Migraines / Seizures / Stroke

Psychiatric: Depression / Anxiety

Respiratory: Asthma / Chest pain / Shortness of breath / Sleep apnea

William F. Sima, M.D., Inc.

Orthopaedic Surgery, Sports Medicine and Joint Replacement

WORKER'S COMPENSATION INJURY INFORMATION

HISTORY OF INJURY

Name _____ Date of the injury _____

What part of your body was injured? _____

Do you feel this injury is work related? ☐ Yes ☐ No If yes, why? _____

_____

Describe how the injury occurred _____

_____

How did you feel immediately after the injury and where did you have the pain? _____

_____

Did you report the injury to your supervisor? ☐ Yes ☐ No Supervisor's name_____

What happened after your injury? (e.g., you were taken to a hospital, you continued working, etc.)

_____

Who has treated you for this problem in the past?

_____ Dates:_____

_____ Dates:_____

_____ Dates:_____

Have you ever injured this body part in the past? ☐ Yes ☐ No

If yes, please explain _____

_____

Did your symptoms begin gradually? ☐ Yes ☐ No

Please describe how you feel now. Do you still have symptoms? If you still have symptoms, please indicate where it hurts, how often, how intense the pain is and if the pain travels:

_____

_____

Do you feel you have a disability resulting from this injury? ☐ Yes ☐ No

If yes, please explain _____

_____

Have you ever had any of the following:

☐ Motor vehicle accident ☐ Motorcycle accident ☐ Fall from any height

☐ Yes ☐ No If yes, please explain _____

_____

NAME_____

Have you ever had a permanent disability as a result of any injury or illness?
☐ Yes ☐ No If yes, when? _____

Please describe the disability _____

_____

WORK HISTORY

What company did you work for at the time of your injury? _____

What date did you begin employment with this company? _____

What position did you hold at the time of the injury? _____

_____

Please describe your normal job duties at time of injury (**including** lifting, bending, reaching, stooping with frequency and weight in pounds, if applicable. Include any protective devices)

_____

_____

Are you still working for this employer? ☐ Yes ☐ No

If **yes,** please answer the following:

Are you doing the same work? ☐ Yes ☐ No

If not, what are your job duties now?_____

_____

If **no**, please answer the following:

Last date worked: _____

Why did you leave?

☐ Lay-off ☐ Termination ☐ Resignation ☐ Other _____

After your injury, did you look for other jobs? ☐ Yes ☐ No

Work History:

Company Name City Job Duties Dates Worked Reason for Leaving

_____

_____

_____

PREVIOUS WORK COMP RELATED INJURIES

Have you ever had previous work comp related injuries? ☐ Yes ☐ No If yes, please list below.

Body part injured Date of injury

_____

_____

Have you ever been considered disabled? ☐ Yes ☐ No If yes, please explain below.

_____

_____

_____ _____

M.D. Review Date

PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1: **Agreement to Arbitrate**: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review or arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional rights to have any such dispute decided on a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: **All Claims Must be Arbitrated:** It is the intention of the parties that this agreement bind all parties whose claims may arise out of or related to treatment or service provided by the physician including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean the mother and the mother's expected child or children.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician, and the physician's partners, associates, association, corporation or partnership, and the employees, agents and estates of any of them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim.

Article 3: **Procedures and Applicable Law:** A demand for arbitration must communicate in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit. The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, nit supplant, any other applicable statutory or common law.

Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of California law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to, Code of Civil Procedure Section 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrations a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure section 1283.05, however, depositions may be taken without prior approval of the neutral arbitrator.

Article 4: **General Provisions:** All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

Article 5: **Revocation:** This agreement may be revoked by written notice delivered to the physician within 30 days, of signature. It is the intent of this agreement to apply to all medical services rendered any time for any condition.

Article 6: **Retroactive Effect:** If patient intends this agreement to cover services rendered before the date it is Effective as of the date of first medical services.

_____
Patient's or Patient Representative's Initials

If any provision if this arbitration agreement is held invalid of unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

By:_____
Patient's or Patient Representative's Signature (Date)

By: _____ _____
Physician or Authorized Representative's Signature (Date)

By:_____
Print Patient's Name

William F. Sima MD, Inc.
Print or Stamp Name of Physician, Medical Group or Association Name

_____
(If Representative, Print Name and Relationship to Patient)

A signed copy of this document is to be given to Patient. Original is to be files in Patient's medical records.
G:front office

Shoulder / Clavicle Evaluation

William F. Sima, M.D.

Name: _____ **Date:**_____

Which shoulder are you being seen for today? Right **Are you**: Right handed
Left Left Handed

Is you shoulder: Catching Stiff
Instability Weak
Painful

Your first symptoms began: Suddenly **As a result of**: A fall Tripping
Gradually Injury MVA
Misstep No injury

In detail please explain how your pain first started _____
_____
_____

What date did this begin? _____

Previous Treatment: I have not received any treatment for this condition

I was evaluated by _____ at:
Twin Cities Hospital Sierra Vista Hospital Family Doctor
French Hospital Urgent Care Other_____

Referring physician: _____

X-rays – Where: _____
MRI – Where: _____
Brace
Physical Therapy - Where: _____
Cortisone Injection
Surgery - With: _____

Severity of Pain: Doing great Same as it was
Much better Worse
Somewhat better

Quality of Pain: Pinching Dull Pulling Stabbing
Achy Gnawing Sharp
Burning Itchy Throbbing

Does the Pain Radiate? Outside of upper arm To the thumb
To the mid upper arm To the hand
To the elbow To the neck
To the wrist To the shoulder blade

Worse with: Reaching over head Sleeping Throwing
Reaching out to side Lifting Combing hair
Reaching behind back Pushing Dressing
Reaching across chest Sports Driving

Weakness: With overhead lifting In shoulder With lifting

Name: _____ **Date:**_____

Paresthesias (tingling): Elbow Hand
Fingers (Thumb Index/Long/Ring/ Small) Shoulder
Forearm Whole Arm

Also experiencing: Grinding Popping
Clicking Cracking

Sports Limitations: Has no limitations
Participates with difficulty in: _____
Unable to participate in: _____

Instability: Shoulder Frequent instability Self reduced instability
Required ER care Dislocated
Stiffness: Yes No

Medications you are taking for shoulder pain:
_____

Medications for pain: Not required
Used occasionally
Required daily

Work Status:
Full duty
Light Duty
Missed work since _____
Unemployed
Retired
Disabled
Homemaker

PAIN:
What amount of shoulder pain have you experienced in the last week doing the following:

1. **Reaching overhead:** ☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Extreme

2. **Reaching behind back:** ☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Extreme

3. **Lifting:** ☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Extreme

FUNCTION (daily living):

4. **Showering and personal hygiene:** ☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Extreme

5. **Putting on shirt:** ☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Extreme

6. **Getting in and out of chair:** ☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Extreme