

Dr. Everhart New Patient Intake Form – Shoulder



IU Health Physicians

Thank you for taking the time to fill out this form. This information will help create the best treatment plan for you and will free up more time for discussion during your appointment.

Sticker

Patient:

DOB:

How did you find out about our clinic?

- Referred by friend or family member
- Referred by school or athletic trainer
- Found info online
- Referred by PT
- Referred by my doctor
- Other: _____

Which shoulder do you want to discuss today? Right Left Both

If both, which one is worse? Right Left Equal

Which is your dominant hand? Right Left Ambidextrous

How long have you had shoulder symptoms? _____

Did your shoulder symptoms start after a specific injury? If yes, please explain:

What symptoms do you have?

- Pain
- Weakness
- Stiffness
- Instability
- Snapping/ clicking / popping / catching
- Numbness / tingling
- Swelling
- Neck pain
- Other: _____

When do you have these symptoms?

- Constant
- Constant baseline w/ intermittent spikes
- Unpredictable
- Intermittent
- Only w/ certain activities: _____

Describe your pain.

- Sharp
- Aching
- Burning
- Stabbing
- Dull
- Throbbing
- Shooting

Rate your pain from 0-10 (0 = no pain, 10 = worst pain) on average: ___/10 at its worst: ___/10.

Where do you have symptoms?

- Front of shoulder
- Side of shoulder
- Back of shoulder
- Top of shoulder

What makes your symptoms worse?

- Overhead activities
- Sleeping on side
- Washing hair
- Putting on a belt
- Throwing
- Exercise
- Reaching out or across you body
- Lifting heavy objects
- Other: _____

What makes your symptoms better?

- Exercise
- Physical therapy
- Medications
- Stretching
- Rest
- Brace/ Sling
- Other: _____

Have you had any previous shoulder injuries? If so, what was it?

Dr. Everhart New Patient Intake Form – Shoulder



IU Health Physicians

What treatments have you had for your shoulder?

- Injection Anti-inflammatory (like Advil or ibuprofen) Physical therapy Surgery
- Other: _____

Are you able to take non-steroidal anti-inflammatory medications (like Advil or ibuprofen?)

- Yes No If no, please list reason why: _____

Have you ever had a shoulder MRI? Yes No

If yes, did they inject dye or medicine? Yes No

If you've had a shoulder injection, what happened to your symptoms?

- Did not help at all Relief for only 2-3 hours Few weeks of relief
- Few months of relief 1 or more years of relief
- Where was the injection placed? _____

If you have had surgery:

Who was your surgeon? _____ When was the surgery? _____

What was the surgery? _____

How did you do with the surgery? _____

What is your occupation? _____

What physical activities do you like to do? _____