Injection Questionnaire (Shoulder) – Week 1

Name: _____ Date: _____

How much pain did you have at that time on a scale of **0** (No pain) to **10** (Worst pain ever):

Day 1	_____	Day 5	_____
Day 2	_____	Day 6	_____
Day 3	_____	Day 7	_____
Day 4	_____		

How many **pills of narcotics** (vicodin, codeine, norco, etc) do you take per day:

Day 1	_____	Day 5	_____
Day 2	_____	Day 6	_____
Day 3	_____	Day 7	_____
Day 4	_____		

Did you have pain that woke you up from sleep or at rest without moving (Circle):

	Night Pain	Rest Pain
Day 1	___ YES / ___ NO	___ YES / ___ NO
Day 2	___ YES / ___ NO	___ YES / ___ NO
Day 3	___ YES / ___ NO	___ YES / ___ NO
Day 4	___ YES / ___ NO	___ YES / ___ NO
Day 5	___ YES / ___ NO	___ YES / ___ NO
Day 6	___ YES / ___ NO	___ YES / ___ NO
Day 7	___ YES / ___ NO	___ YES / ___ NO

For the following questions, please indicate the difficulty of the following activities with a number:
(**0** – Unable to do **1** – Very difficult to do **2** – Somewhat difficult to do **3** – Not difficult to do)

	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
Putting on a coat	____	____	____	____	____	____	____
Sleeping	____	____	____	____	____	____	____
Washing your body	____	____	____	____	____	____	____
Wiping your bottom	____	____	____	____	____	____	____
Combing your hair	____	____	____	____	____	____	____
Reaching out	____	____	____	____	____	____	____
Lifting your arm	____	____	____	____	____	____	____
Throwing a ball	____	____	____	____	____	____	____
Working	____	____	____	____	____	____	____
Playing sports	____	____	____	____	____	____	____

When did you return to work: _____
Date of Discharge: _____

Please return or fax to Dr. Alan Hirahara at (916) 732-3023.
If you have any questions, please contact my assistant, Heather, at (916) 732-3017.
You may also return the form via email to hvincentsoc@hotmail.com

Injection Questionnaire (Shoulder) – Month 1

Name: _____ Date: _____

How much pain did you have at that time on a scale of **0** (No pain) to **10** (Worst pain ever):

2 weeks after injection _____
3 weeks after injection _____
4 weeks after injection _____

How many **pills of narcotics** (vicodin, codeine, norco, etc) do you take per day:

2 weeks after injection _____
3 weeks after injection _____
4 weeks after injection _____

Did you have pain that woke you up from sleep or at rest without moving (Circle):

	Night Pain	Rest Pain
Week 2	___ YES / ___ NO	___ YES / ___ NO
Week 3	___ YES / ___ NO	___ YES / ___ NO
Week 4	___ YES / ___ NO	___ YES / ___ NO

For the following questions, please indicate the difficulty of the following activities with a number:

(**0** – Unable to do **1** – Very difficult to do **2** – Somewhat difficult to do **3** – Not difficult to do)

	Week 2	Week 3	Week 4
Putting on a coat	_____	_____	_____
Sleeping	_____	_____	_____
Washing your body	_____	_____	_____
Wiping your bottom	_____	_____	_____
Combing your hair	_____	_____	_____
Reaching out	_____	_____	_____
Lifting your arm	_____	_____	_____
Throwing a ball	_____	_____	_____
Working	_____	_____	_____
Playing sports	_____	_____	_____

When did you return to work: _____
Date of Discharge: _____

Flexion: _____ Abduction: _____ ER: _____

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Injection Questionnaire (Shoulder) – Months 2 - 6

Name: _____ Date: _____

How much pain did you have at that time on a scale of **0** (No pain) to **10** (Worst pain ever):

2 months after injection _____
3 months after injection _____
4 months after injection _____
5 months after injection _____
6 months after injection _____

How many **pills of narcotics** (vicodin, codeine, norco, etc) do you take per day:

2 months after injection _____
3 months after injection _____
4 months after injection _____
5 months after injection _____
6 months after injection _____

Did you have pain that woke you up from sleep or at rest without moving (Circle):

	Night Pain	Rest Pain
Month 2	___ YES / ___ NO	___ YES / ___ NO
Month 3	___ YES / ___ NO	___ YES / ___ NO
Month 4	___ YES / ___ NO	___ YES / ___ NO
Month 5	___ YES / ___ NO	___ YES / ___ NO
Month 6	___ YES / ___ NO	___ YES / ___ NO

For the following questions, please indicate the difficulty of the following activities with a number:
(**0** – Unable to do **1** – Very difficult to do **2** – Somewhat difficult to do **3** – Not difficult to do)

	Month 2	Month 3	Month 4	Month 5	Month 6
Putting on a coat	_____	_____	_____	_____	_____
Sleeping	_____	_____	_____	_____	_____
Washing your body	_____	_____	_____	_____	_____
Wiping your bottom	_____	_____	_____	_____	_____
Combing your hair	_____	_____	_____	_____	_____
Reaching out	_____	_____	_____	_____	_____
Lifting your arm	_____	_____	_____	_____	_____
Throwing a ball	_____	_____	_____	_____	_____
Working	_____	_____	_____	_____	_____
Playing sports	_____	_____	_____	_____	_____

When did you return to work: _____
Date of Discharge: _____

Please return or fax to Dr. Alan Hirahara at (916) 732-3023.
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