Injection Questionnaire (Shoulder) – Pre-Injection

Name: ____________________________________________  Date: ________________

How would you like to be contacted regarding this study: ___ E-Mail/___ Fax / ___ Mail

Please give us your Email or Fax: _______________________________________________

How much pain did you have today on a scale of 0 (No pain) to 10 (Worst pain ever):
Before injection __________

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

Did you have pain that woke you up from sleep or at rest without moving (Circle):
Night Pain | Rest Pain
Before injection ___ 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)

Before injection
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 ________

PT Evaluation:

<table>
<thead>
<tr>
<th>ROM</th>
<th>Strength</th>
</tr>
</thead>
<tbody>
<tr>
<td>Forward Elevation: ________</td>
<td>________</td>
</tr>
<tr>
<td>Abduction: ________</td>
<td>________</td>
</tr>
<tr>
<td>External Rotation: ________</td>
<td>________</td>
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</tbody>
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Notes: _______________________________________________________________________________