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:

	ROM	Strength
Forward Elevation:	_____	_____
Abduction:	_____	_____
External Rotation:	_____	_____

Notes: _____