1. **DO YOU HAVE PAIN IN YOUR SHOULDER?**  
   - NONE  
   - MILD  
   - MODERATE  
   - SEVERE

2. **Place an X on the line below to describe your shoulder pain level during normal activity**
   - Hand behind head  
   - Hand on top of head  
   - Full elevation from (hand) top of head

### Function

1. Does your shoulder limit your occupation or daily living?  
   - No, or very slightly  
   - Moderate limitation  
   - Severe limitation

2. Are your leisure and recreational activities limited by your shoulder?  
   - No, or very slightly  
   - Moderate limitation  
   - Severe limitation

3. Does your shoulder disturb your night sleep?  
   - No  
   - Sometimes  
   - Yes

4. What level can you use your arm for reasonable painless movement?  
   - Waist  
   - Chest  
   - Neck  
   - Ear  
   - Above head

### Movement

#### 1. Forward Elevation in degrees (from arm by side)

- LEFT:  
  - 0 - 30  
  - 31 - 60  
  - 61 - 90  
  - 91 - 120  
  - 121 - 150  
  - 151 - 180

- RIGHT:
  - 0 - 30  
  - 31 - 60  
  - 61 - 90  
  - 91 - 120  
  - 121 - 150  
  - 151 - 180

#### 2. Lateral Elevation in degrees (from arm by side)

- LEFT:
  - 0 - 30  
  - 31 - 60  
  - 61 - 90  
  - 91 - 120  
  - 121 - 150  
  - 151 - 180

- RIGHT:
  - 0 - 30  
  - 31 - 60  
  - 61 - 90  
  - 91 - 120  
  - 121 - 150  
  - 151 - 180

#### 3. External Rotation  
- Hand behind head with elbow held forward  
- Hand behind head with elbow held back  
- Hand on top of head with elbow held forward  
- Hand on top of head with elbow held back  
- Full elevation from (hand) top of head

#### 4. Internal Rotation  
- Hand behind back to lateral thigh  
- Hand behind back to buttock  
- Hand behind back to lumbosacral junction  
- Hand behind back to waist (3rd lumbar vertebra)  
- Hand behind back to 12th thoracic vertebra  
- Hand behind back to interscapular level

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*Please continue answering the questions on page 2.*
**CONSTANT SCORE AND ADDITIONAL QUESTIONS FOR VERSO SHOULDER**

<table>
<thead>
<tr>
<th>HOSP NO:</th>
<th>STUDY NO:</th>
</tr>
</thead>
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<table>
<thead>
<tr>
<th>HOSPITAL:</th>
<th>FOLLOW-UP:</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>O PRE-OP</td>
</tr>
<tr>
<td></td>
<td>O 3 MONTHS</td>
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<tr>
<td></td>
<td>O 6 WEEKS</td>
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<td></td>
<td>O 6 MONTHS</td>
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<td>O 1 YEAR</td>
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<tr>
<td></td>
<td>O OTHER (PLEASE SPECIFY)</td>
</tr>
<tr>
<td>SIDE:</td>
<td>MONTHS:</td>
</tr>
<tr>
<td>LEFT</td>
<td>RIGHT</td>
</tr>
</tbody>
</table>

| Internal rotation in 90° of abduction: |
| LEFT: | RIGHT: |
| ° | ° |

| External rotation in adduction with the arm beside the body: |
| LEFT: | RIGHT: |
| ° | ° |

| POWER: Number of pounds resisted at 90° of lateral elevation (maximum 25lbs) |
| Left: | Right: |
| kg | lbs |

Place an X on the line below to describe how satisfied you are with your shoulder.

- ☹ Not satisfied
- 0 1 2 3 4 5 6 7 8 9 10! Very satisfied 😊

What is your occupation:

1. How well can you perform your occupation?
   - Easa
   - With little difficulty
   - Moderate difficulty
   - Extreme difficulty
   - Not at all

2. What are your two main sporting/leisure activities:

3. How well can you perform these activities?
   - Easily
   - With little difficulty
   - Moderate difficulty
   - Extreme difficulty
   - Not at all

**ONLY COMPLETE THIS SECTION AFTER YOUR OPERATION:**

<table>
<thead>
<tr>
<th>Operation:</th>
<th>Date of Surgery:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>D D / M M / Y Y Y</td>
</tr>
</tbody>
</table>

How do you feel NOW following your operation?

- Much better
- Better
- Same
- Worse

Have you NOW returned to the same occupation?
   - Yes
   - No

Have you NOW returned to the same occupation but with decreased level of activity (due to the shoulder)?
   - Yes
   - No

If yes, what is your occupation NOW?

Have you NOW changed occupation due to the shoulder?
   - Yes
   - No

Have you NOW stopped working all together due to your shoulder?
   - Yes
   - No

Have you NOW returned to the same level of activity in the same sport?
   - Yes
   - No

Have you NOW returned to a decreased level of activity in the same sport (due to the shoulder)?
   - Yes
   - No

If yes, what sport have you changed to?

Have you NOW stopped playing sport all together due to your shoulder?
   - Yes
   - No

Signature: ____________________________

Date: D D / M M / Y Y Y

Thank you for your help in completing this form.