

Reading Shoulder Unit

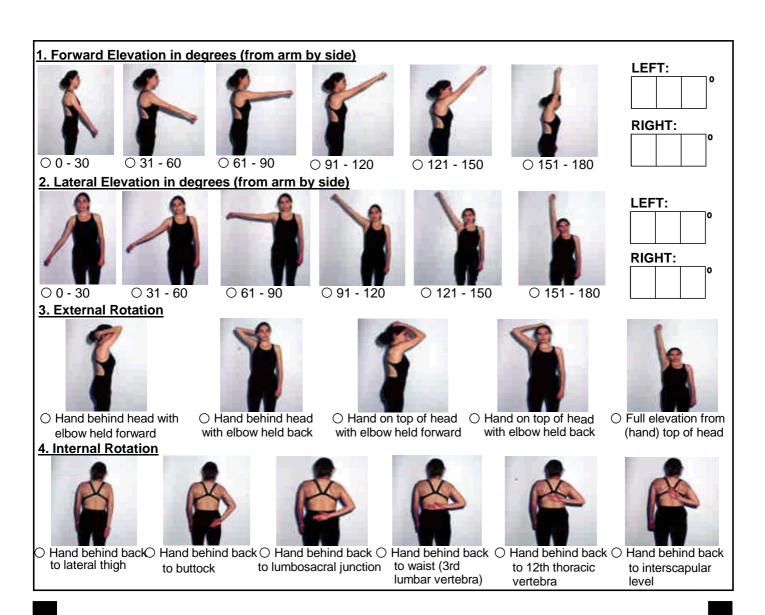


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Draft	CONSTANT SCORE AND ADDITIONAL QUESTIONS FOR VERSO SHOULDER Page 1			
HOSP NO:				
HOSPITAL:	STUDY NO:			
FOLLOW-UP:	GENDER: SIDE O Male O Female O LEFT O RIGHT			
_	PRE-OP O 3 MONTHS O 1 YEAR YEARS: MONTHS: 6 WEEKS O 6 MONTHS OTHER (PLEASE SPECIFY)			
EVALUATOR:	Shade Circles Like This> ●			
1. DO YOU HAVE PAIN IN YOUR SHOULDER? O NONE O MILD O MODERATE O SEVERE				
	line below to describe your shoulder pain level during normal activity			
○ No pain 0 1	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 Unbearable Pain			
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 slightlyModerate limitationSevere limitation				
3. Does your shoulder disturb your night sleep? No O Sometimes O Yes				
4. What level can you use your arm for reasonable painless movement? Waist Chest Neck Ear Above head				



CONSTANT SCORE AND ADDITIONAL QUESTIONS FOR VERSO SHOULDER



Please continue answering the questions on page 3.



CONSTANT SCORE AND ADDITIONAL QUESTIONS FOR VERSO SHOULDER

Page 3



HOSP NO:			STUDY NO:			
HOSPITAL:		Shade Circles Lik	SIDE ce This> ◆ ○ LEFT ○ RIGHT			
FOLLOW-UP: O PRE-OP O:	3 MONTHS 0 1 '	YEAR YEA				
O 6 WEEKS O 6 MONTHS O THER (PLEASE SPECIFY) MONTHS: O 1 YEAR O 1 YEAR O THER (PLEASE SPECIFY)						
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:						
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? ○ Easily ○ With little difficulty ○ Moderate difficulty ○ Extreme difficulty ○ Not at all 2. What are your two main sporting/leisure activities:						
The state of the s						
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:						
Operation:		Date of Surgery: D D				
How do you feel NOW following your operation? O Much better O Better O Same O Worse						
Have you NOW returned to the same occupation? O Yes O No						
Have you NOW returned to the same occupation but O Yes O No with decreased level of activity (due to the shoulder)?						
Have you NOW changed occupation due to the shoulder? O Yes O No						
If yes, what is your occupation NOW?						
Have you NOW stopped working all together due to your shoulder? O Yes O No						
Have you NOW returned to the same level of activity in the same sport? O Yes O No Have you NOW returned to a decreased level of activity in the same O Yes O No sport (due to the shoulder)?						
Have you NOW changed sports due to the shoulder? O Yes O No						
If yes, what sport have you chang	ged to?					
Have you NOW stopped playing sport all together due to your shoulder? ○ Yes ○ No						

Signature	Date:
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	D D MM YYYY

Thank you for your help in completing this form.

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