

# PATIENT OUTCOMES ASSESSMENT **SHOULDER**

## DEMOGRAPHIC DATA

**1** Today's date  
(day/month/year) / / /

**2** Which shoulder is troubling you currently? (Please tick one box)

Right <sup>1</sup>  Left <sup>2</sup>  Both <sup>3</sup>

**3** For how long (approximately), have you had a problem with this shoulder?

.....Years/.....Months

**4** Did this shoulder problem start suddenly or did it come on slowly?

(Please tick one box)

Suddenly <sup>1</sup>  Slowly <sup>2</sup>

**5** Did this shoulder problem start with a sports injury, work injury, other accident or fall? (Please tick one box)

Sports injury <sup>1</sup>

Work injury <sup>2</sup>

Other accident/fall <sup>3</sup>

None of the above <sup>4</sup>

**6** Does the problem of your shoulder involve a legal claim for compensation? (Please tick one box)

Yes <sup>1</sup>

No <sup>2</sup>

**7** Are you right or left-handed?  
(Please tick one box)

Right-handed <sup>1</sup>

Left-handed <sup>2</sup>

Neither/both <sup>3</sup>

**8** What is your date of birth?  
(day/month/year) / / /

**9** Are you... (Please tick one box)

Male? <sup>1</sup>  or Female? <sup>2</sup>

**10** Are you in paid employment?

Yes <sup>1</sup>  No <sup>2</sup>

IF YES,  
(Please tick one box)

**a** Do you work ... Full-time? <sup>1</sup>

Part-time? <sup>2</sup>

IF NO,

**b** Have you retired? Yes <sup>1</sup>

No <sup>2</sup>

**11** Do you regularly (at least once a week) spend time caring for children or dependent adults? (Please tick one box)

Yes <sup>1</sup>

No <sup>2</sup>