DR. WEBER SHOULDER INFORMATION SHEET

Name:_________________________________ DOB:__________ Date:_________

In order to make your evaluation and treatment more efficient, we would appreciate you completing this questionnaire as accurately as possible.

1. Is your shoulder problem injury related? Yes____ No____
2. How were you injured? Sports____ Work____ Motor Vehicle___ Other___
3. How long has the shoulder been painful? ___________________________
4. Which shoulder is painful? Right_____ Left_____Both_____
5. What type of problems are you having with your shoulder?____________

   ____
6. Are you Right or Left handed? Please circle appropriate answer.
7. Any previous history of shoulder, neck or back problems? Yes____ No____
8. Do you take any medication for your shoulder? Yes____ No____

   If yes, what medication and dosage__________________________
9. Have you had a cortisone injection to the shoulder? Yes_____ No_____
10. Have you had physical therapy for the shoulder? Yes_____ No______

    If yes, where and for how long, and has it helped___________________
11. Have you ever had an operation on your shoulder? Yes____ No___

    If yes, what operation? ______________________________________