

Reading Shoulder Unit

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Shoulder assessment	questionnaire.	(Constant Score and Satisfaction Score)

Shoulder assessment question	Constant Store and Satisfaction Store
	Date:
Patient identification label	Side: Right / Left
Discos take a few minutes to fill in this question	This an accontict part of our evaluation
•	onnaire. It is an essential part of our evaluation and will help us improve the service we provide.
Please complete this form by circling the most	·
	<u>. uppropriato respenses.</u>
A. Pain	
	ng normal activities? (Please circle most
appropriate response)	
1. NO PAIN 2. MILD PAIN 3	3. MODERATE PAIN 4. SEVERE PAIN
A2: If 0 means 'no pain' and 15 means the	'worst pain' you can have, please circle the
•	pain when you are doing <u>normal</u> activities.
© 0 12345 6789	9 10 11 12 13 14 15
1 NA 11	* ""
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	ATE SEVERE UNBEARABLE
NO PAIN MILD MODER B. Function (Please circle most appropriate	ATE SEVERE UNBEARABLE e response)
NO PAIN MILD MODER B. Function (Please circle most appropriate B1: Does your shoulder limit your occupation	ATE SEVERE UNBEARABLE e response) on or daily living?
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O. W. J. D. Const. Co. Co.				
C. Work/Recreation (Please circle most appropriate response) C1: What is your occupation?				
C2: How well can you perform your occupation (or daily activities if retired)?				
1. EASILY 2. WITH LITTLE DIFFICULTY 3. WITH MODERATE DIFFICULTY				
4. WITH EXTREME DIFFICULTY 5. NOT AT ALL				
C3: What are your two main sporting or leisure activities?				
, , , , , , , , , , , , , , , , , , , ,				
C4: How well can you perform these activities?				
1. EASILY 2. WITH LITTLE DIFFICULTY 3. WITH MODERATE DIFFICULTY				
4. WITH EXTREME DIFFICULTY 5. NOT AT ALL				
D. Post operative questions (Please circle most appropriate response)				
Operation: Date of op:				
Please only answer this section if you have had a shoulder operation.				
D1: How do you feel now, following your operation?				
1. MUCH BETTER 2. BETTER 3. SAME 4. WORSE				
D2: Have you now:				
 i) Returned to the same occupation / normal daily activities (if retired)? ii) Returned to the same occupation but with decreased level of activity (due to shoulder)? iii) Changed occupation due to your shoulder? 				
iv) Stopped working altogether because of your shoulder?				
D3: If you have changed occupation, what job do you do now?				
D4: Have you now :				
1. Returned to the same level of activity in the same sport?				
2. Returned to a decreased level of activity in the same sport (due to shoulder)?				
3. Changed sports because of your shoulder?				
Stopped playing sports altogether because of your shoulder?If you have changed sports, what have you changed to?				
Comments Please use space below for any further comments you'd like to make.				
Additional comments can be put on t he last page if necessary				

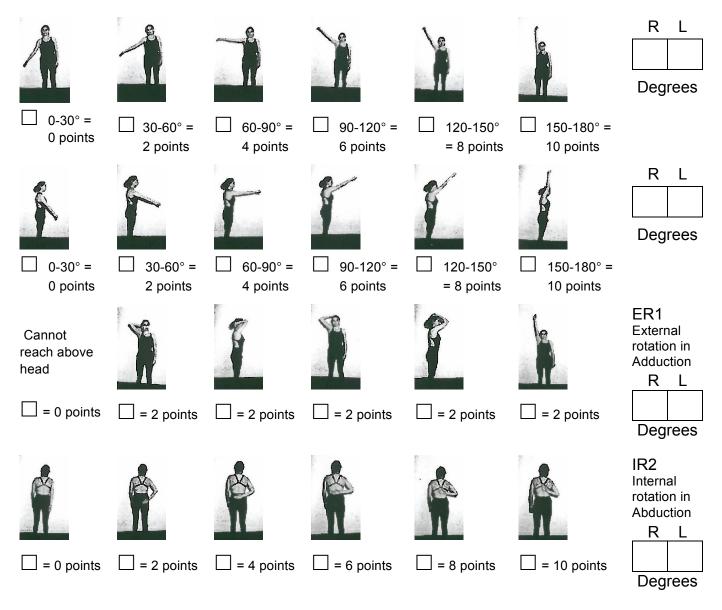
Thank you for completing this questionnaire.

Movement (to be completed with assistance from doctor or nurse)

Relevant side

Starting from left to right, tick the box below each picture if patient able to perform the action 'Pain free'. Leave the box blank if patient unable to do the action.

Mark the 'Pain free' range of motion in degrees in the two boxes on the right side of page.



Strength

The doctor or nurse will test your strength with a resistance device (Isometer).

RIGHT		LEFT	
Kg	Lb	Kg	Lb

Additional comments:-		