

Name: _____ **Date:** _____

Age: _____ **Sex:** Male ___ Female ___ **Dominant Hand:** Right ___ Left ___

Diagnosis: _____

1. Pain is difficult to describe. Circle the words that best describe your symptoms:

Burning Throbbing Aching Stabbing Tingling Twisting Squeezing
 Cramping Cutting Shooting Numbing Vague Stinging Indescribable
 Pulling Smarting Pressure Coldness Dull Other: _____

Level of symptoms: place a mark through the line to indicate the level of your pain, if zero is no pain and the end of the line is the most severe pain you can imagine having.

2. Mark your average level of pain in the last month

1 _____ 5 _____ 10
 No Pain Most Severe Pain

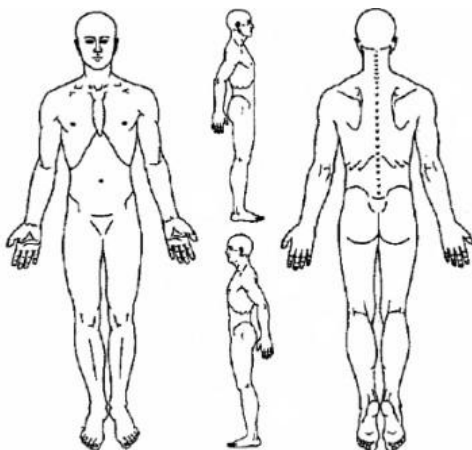
3. Mark your worst level of pain in the last week

1 _____ 5 _____ 10

4. Mark on this scale how your pain has affected your quality of life:

1 _____ 5 _____ 10
 Very Little A large amount

5. Where is your pain? (Draw on diagram)



Name _____

6. How did the pain that you are now experiencing occur?
Sudden onset Slow progressive onset "Flare up" of a prior injury

7. Does movement have any effect on your pain?
Makes it better Makes it worse No change

8. Does weather have any effect on your pain?
Makes it better Makes it worse No change

9. Do you have trouble with sleep because of your pain?
Trouble falling asleep awakened from sleep No trouble sleeping

10. Are you involved in any legal action regarding your physical complaint?
No Yes

11. Are you presently a victim of abuse?
No Yes No comment

12. Are you able to do your normal work and/or household chores?
Limited a lot Limited a little Not limited at all

13. How would you rate your overall health?
Excellent Good Fair Poor

Describe the problem for which you seek physical therapy _____

Describe how are you taking care of the problem now _____

Describe what makes the problem better and what makes it worse _____

Please list your goals for physical therapy. What would you like to be able to do when you are finished? Please be as specific as possible.

If there is any medical or medication history that has changed since the last time you saw your doctor? _____

Shoulder Pain and Disability Index

Please place a mark on the line that best represents your experience during the last week attributable to your shoulder problem.

Pain scale

How severe is your pain?

Circle the number that best describes your pain where: **0** = no pain and **10** = the worst pain imaginable.

At its worst?	0	1	2	3	4	5	6	7	8	9	10
When lying on the involved side?	0	1	2	3	4	5	6	7	8	9	10
Reaching for something on a high shelf?	0	1	2	3	4	5	6	7	8	9	10
Touching the back of your neck?	0	1	2	3	4	5	6	7	8	9	10
Pushing with the involved arm?	0	1	2	3	4	5	6	7	8	9	10

Total pain score _____ / 50 x 100 = _____ %

(Note: If a person does not answer all questions divide by the total possible score, eg. if 1 question missed divide by 40)

Disability scale

How much difficulty do you have?

Circle the number that best describes your experience where: **0** = no difficulty and **10** = so difficult it requires help

Washing your hair?	0	1	2	3	4	5	6	7	8	9	10
Washing your back?	0	1	2	3	4	5	6	7	8	9	10
Putting on an undershirt or jumper?	0	1	2	3	4	5	6	7	8	9	10
Putting on a shirt that buttons down the front?	0	1	2	3	4	5	6	7	8	9	10
Putting on your pants?	0	1	2	3	4	5	6	7	8	9	10
Placing an object on a high shelf?	0	1	2	3	4	5	6	7	8	9	10
Carrying a heavy object of 10 pounds (4.5 kilograms)	0	1	2	3	4	5	6	7	8	9	10
Removing something from your back pocket?	0	1	2	3	4	5	6	7	8	9	10

Total disability score: _____ / 80 x 100 = _____ %

(Note: If a person does not answer all questions divide by the total possible score, eg. if 1 question missed divide by 70)

Total Spadi score: _____ 130 x 100 = _____ %

(Note: If a person does not answer all questions divide by the total possible score, eg if 1 question missed divide by 120)

Minimum Detectable Change (90% confidence) = 13 points

(Change less than this may be attributable to measurement error)

Source: Roach et al. (1991). Development of a shoulder pain and disability index.



Valued COPC Physical Therapy Patient:

At Central Ohio Primary Care, it is our goal to give you the best care possible. In order to best serve all of our patients, we request the following:

- If you cannot keep your scheduled appointment, please call us at the number above to cancel the appointment at least 24 hours prior to the visit.
- If you miss an appointment, and fail to call to re-schedule or cancel, you may be assessed a No Show/Late Cancellation fee of \$50.00 for an initial evaluation or \$25.00 for an established follow-up visit.
- If you have 3 cancellations within a consecutive 3 week period, the Physical Therapist will be notified and will determine if your therapy should resume, or be discontinued.
- If you will be more than 10 minutes late, we may ask you to re-schedule your appointment. This will assure that we are giving you the full time you deserve to address all of your needs during treatment.

Thank you for helping us to provide our patients with the most convenient scheduling possible!

I have read this physical therapy policy and agree to the above.

Today's Date: _____

Printed Name: _____

Signature: _____