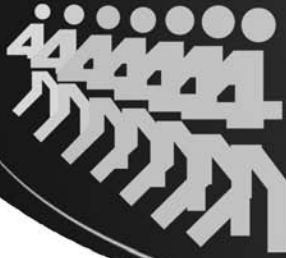


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## Shoulder Chart History

Created 05/12/2009

Name: \_\_\_\_\_ Date: \_\_\_\_\_ Age: \_\_\_\_\_

Shoulder Problem: \_\_\_\_\_  Right  Left

Are You Generally:  Right handed  Left handed

Date of Onset: \_\_\_\_\_ Injury:  Yes  No (Describe Injury) \_\_\_\_\_

How Did Pain or Problem Begin? \_\_\_\_\_

## Symptoms

Is your shoulder problem	<input type="checkbox"/> intermittent	<input type="checkbox"/> constant
Soreness/Aching	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Pain with reaching or overhead activities	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Popping, clicking, grinding	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Loss of motion	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Stiffness	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Weakness	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Numbness	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Tenderness	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Does shoulder pain wake you or keep you awake	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Neck and/or arm pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Can you sleep on the affected side	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Past shoulder problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Family history of shoulder problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you in good general health	<input type="checkbox"/> Yes	<input type="checkbox"/> No