Date:

PATIENT SELF-EVALUATION

SF-36

This survey asks for your views about your health. This information will help you keep track of how you feel and how well you are able to do your usual activities. Answer every question by selecting the answer as indicated. If you are unsure about how to answer a question, please give the best answer you can.

1. In general, would you say your health is: [Check the box that best describes your answer.]

Excellent	Very Good	Good	Fair	Poor
☐	☐	☐	☐	☐

2. *Compared to one year ago,* how would you rate your health in general now?

Much better now than one year ago	Somewhat better now than one year ago	About the same as one year ago	Somewhat worse now than one year ago	Much worse now than one year ago
☐	☐	☐	☐	☐

3. The following questions are about activities you might do during a typical day. *Does your health now limit* you in these activities? If so, how much? [Check a box on each line.]

		Yes, limited a lot	Yes, limited a little	No, not limited at all
a.	*Vigorous Activities,* such as running, lifting heavy objects, participating in strenuous sports	☐	☐	☐
b.	*Moderate Activities,* such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	☐	☐	☐
c.	Lifting or carrying groceries	☐	☐	☐
d.	Climbing *several* flights of stairs	☐	☐	☐
e.	Climbing *one* flight of stairs	☐	☐	☐
f.	Bending, kneeling, or stooping	☐	☐	☐
g.	Walking *more than a mile*	☐	☐	☐
h.	Walking *several hundred yards*	☐	☐	☐
i.	Walking *one hundred yards*	☐	☐	☐
j.	Bathing or dressing yourself	☐	☐	☐

4. During the *past 4 weeks,* how much of the time have you had any of the following problems with your work or other regular daily activities *as a result of your physical health?*

		All of the time	Most of the time	Some of the time	A little of the time	None of the time
a.	Cut down on the *amount of time* you spent on work or other activities	☐	☐	☐	☐	☐
b.	*Accomplished* less than you would like	☐	☐	☐	☐	☐
c.	Were limited in the *kind* of work or other activities	☐	☐	☐	☐	☐
d.	Had *difficulty* performing the work or other activities (for example, it took extra effort)	☐	☐	☐	☐	☐

5. During the *past 4 weeks,* how much of the time have you had any of the following problems with your work or other regular daily activities *as a result of any emotional problems* (such as feeling depressed or anxious)?

		All of the time	Most of the time	Some of the time	A little of the time	None of the time
a.	Cut down on the *amount of time* you spent on work or other activities	☐	☐	☐	☐	☐
b.	*Accomplished less* than you would like	☐	☐	☐	☐	☐
c.	Did work or activities *less carefully than usual*	☐	☐	☐	☐	☐

6. During the *past 4 weeks,* to what *extent* has your *physical health or emotional problems* interfered with your normal social activities with family, friends, neighbors, or groups?

Not at all ☐ Slightly ☐ Moderately ☐ Quite a bit ☐ Extremely ☐

7. How much *bodily* pain have you had during the *past 4 weeks*?

None ☐ Very mild ☐ Mild ☐ Moderate ☐ Severe ☐ Severe ☐

8. During the *past 4 weeks,* how much did *pain* interfere with your normal work (including both work outside the home and housework)?

Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely ☐

9. These questions are about how you feel and how things have been with you *during the past 4 weeks*. For each question, please give the one answer that comes closest to the way you have been feeling. How much of the time during the *past 4 weeks*...

		All of the time	Most of the time	Some of the time	A little of the time	None of the time
a.	Did you feel full of life?	☐	☐	☐	☐	☐
b.	Have you been very nervous?	☐	☐	☐	☐	☐
c.	Have you felt so down in the dumps that nothing could cheer you up?	☐	☐	☐	☐	☐
d.	Have you felt calm and peaceful?	☐	☐	☐	☐	☐
e.	Did you have a lot of energy?	☐	☐	☐	☐	☐
f.	Have you felt downhearted and depressed?	☐	☐	☐	☐	☐
g.	Did you feel worn out?	☐	☐	☐	☐	☐
h.	Have you been happy?	☐	☐	☐	☐	☐
i.	Did you feel tired?	☐	☐	☐	☐	☐

10. During the *past 4 weeks,* how much of the time has your *physical health or emotional problems* interfered with your social activities (like visiting friends, relatives, etc.)?

All of the time ☐ Most of time ☐ Some of the time ☐ A little of the time ☐ None of the time ☐

11. How TRUE or FALSE is *each* of the following statements for you?

		Definitely true	Mostly true	Don't know	Mostly false	Definitely false
a.	I seem to get sick a little easier than other people	☐	☐	☐	☐	☐
b.	I am as healthy as anybody I know	☐	☐	☐	☐	☐
c.	I expect my health to get worse	☐	☐	☐	☐	☐
d.	My health is excellent	☐	☐	☐	☐	☐

SIMPLE SHOULDER TEST

Which is your affected shoulder: Right ☐ Left ☐

Please answer each of the questions below for **BOTH YOUR AFFECTED AND UNAFFECTED** shoulder**.** Please do not leave any questions unanswered. If you would like to add comments, please do so below this page.

		RIGHT	LEFT		
1.	Is your shoulder comfortable with your arm at rest by your side?	Yes	No	Yes	No
2.	Does your shoulder allow you to sleep comfortably?	Yes	No	Yes	No
3.	Can you reach the small of your back to tuck in your shirt with your hand?	Yes	No	Yes	No
4.	Can you place you hand behind your head with the elbow straight out to the side?	Yes	No	Yes	No

5. Can you place a coin on a shelf at the level of your shoulder without bending your elbow?	Yes	No	Yes	No
6. Can you lift one pound (a full pint container) to the level of your shoulder without bending your elbow?	Yes	No	Yes	No
7. Can you lift eight pounds (a full gallon container) to the top of your head without bending your elbow?	Yes	No	Yes	No
8. Can you carry 20 pounds (a bag of potatoes) at your side with the affected extremity?	Yes	No	Yes	No
9. Do you think you can toss a softball under-hand ten yards with the affected extremity?	Yes	No	Yes	No
10. Do you think you can throw a softball over-hand twenty yards with the affected extremity?	Yes	No	Yes	No
11. Can you wash the back of your opposite shoulder with the affected extremity?	Yes	No	Yes	No
12. Would your shoulder allow you to work full time at your regular job?	Yes	No	Yes	No

ASES

Please answer questions 1-23 below for **BOTH YOUR AFFECTED AND UNAFFECTED** shoulder**.** Please do not leave any questions unanswered. If you would like to add comments, please do so on below this page.

1. How bad is your pain today on a scale from 0 to 10? (0 = no pain at all, 10 = pain as bad as it can be) (*circle correct answer)*	0,1,2,3,4,5,6,7,8,9,10	0,1,2,3,4,5,6,7,8,9,10

Circle the number in the box that indicates your ability to do the following activities:

0 = Unable to do; 1 = Very difficult to do; 2 = Somewhat difficult; 3 = Not difficult

Activity		*Right Arm*		*Left Arm*	
2. Put on a coat		0 1 2 3		0 1 2 3	
3. Sleep on your painful or affected aside		0 1 2 3		0 1 2 3	
4. Wash back / do up bra in back		0 1 2 3		0 1 2 3	
5. Manage toiletting		0 1 2 3		0 1 2 3	
6. Comb hair		0 1 2 3		0 1 2 3	
7. Reach a high shelf		0 1 2 3		0 1 2 3	
8. Lift 10 lbs. above shoulder		0 1 2 3		0 1 2 3	
9. Throw a ball overhand		0 1 2 3		0 1 2 3	
10. Do usual work -	List_____	0 1 2 3		0 1 2 3	
11. Do usual sport –	List:_____	0 1 2 3		0 1 2 3	
12. Are you able to do your work as fully as usual?		Yes	No	Yes	No
13. Are your able to participate in recreational activities as fully as usual?		Yes	No	Yes	No
14. Is your sleep affected by your shoulder?		Yes	No	Yes	No
15. How high can you reach your hand?		a. Up to waist b. Up to sternum c. Up to neck d. Up to top of head e. Above head		a. Up to waist b. Up to sternum c. Up to neck d. Up to top of head e. Above head	