

## SHOULDER INJURY SELF-ASSESSMENT OF FUNCTION

Patient Name \_\_\_\_\_

Date \_\_\_\_\_

**Please read carefully:**

*Please rate your ability to do the following common tasks as they relate to your injured shoulder.  
Mark one answer to each question.*

TASK	Normal	Mild Compromise	Difficult	Very Difficult (with aid)	Unable
1. Use back pocket					
2. Wipe after bowel movement					
3. Wash opposite underarm					
4. Eat with fork or spoon					
5. Comb hair					
6. Use hand with arm at shoulder level					
7. Carry 10-15 pounds with arm at side					
8. Dress					
9. Sleep on affected side					
10. Pulling					
11. Use hand overhead					
12. Throwing					
13. Lifting					
14. Do usual work					
15. Do usual sport					

**COMMENTS:** \_\_\_\_\_  
\_\_\_\_\_

**EXAMINER:** \_\_\_\_\_

## SHOULDER PAIN AND DISABILITY INDEX (SPADI)

Patient Name \_\_\_\_\_

Date \_\_\_\_\_

### Please read carefully:

Instructions: Please circle the number that best describes the question being asked.

#### Pain scale:

No pain at all 0 1 2 3 4 5 6 7 8 9 10 Worst pain Imaginable

#### How severe is your pain?

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

#### Disability scale:

No difficulty 0 1 2 3 4 5 6 7 8 9 10 So difficult it requires help

#### How much difficulty do you have?

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

**OTHER COMMENTS:** \_\_\_\_\_

**Examiner:** \_\_\_\_\_

# QUADRUPLE VISUAL ANALOGUE SCALE

Patient Name \_\_\_\_\_

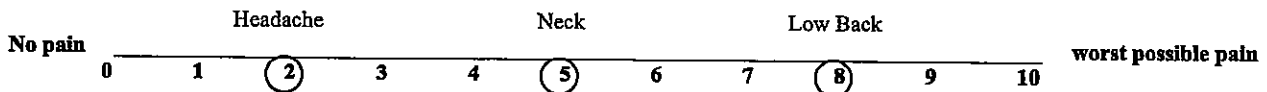
Date \_\_\_\_\_

**Please read carefully:**

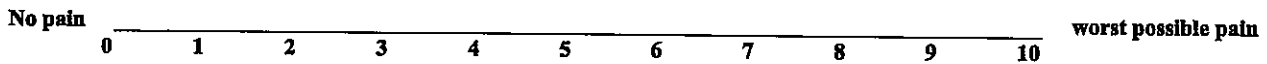
**Instructions:** Please circle the number that best describes the question being asked.

**Note:** If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

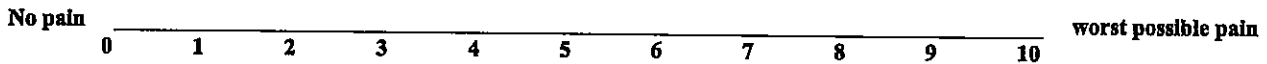
**Example:**



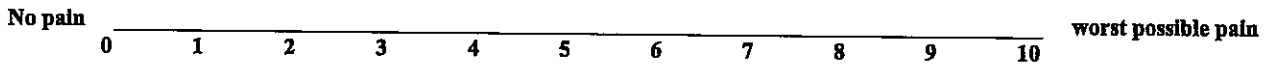
**1 – What is your pain RIGHT NOW?**



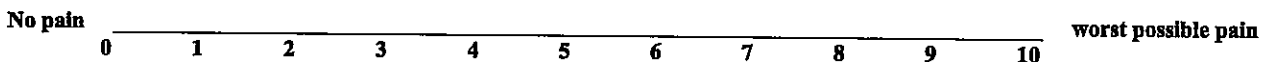
**2 – What is your TYPICAL or AVERAGE pain?**



**3 – What is your pain level AT ITS BEST (How close to “0” does your pain get at its best)?**



**4 – What is your pain level AT ITS WORST (How close to “10” does your pain get at its worst)?**



**OTHER COMMENTS:**

\_\_\_\_\_  
\_\_\_\_\_

Examiner \_\_\_\_\_

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