PAIN SHEET

Shoulder Evaluation

Name	Birth date	Referred by	Today's Date
______________________	___/___/____	Dr.______________	___/___/____
Last First Middle Init.	mm/dd/yyyy		mm/dd/yyyy

– These questions apply only to the area being scanned today –

1. What was your chief complaint when you visited your doctor? ______________________________

   ____

2. What do you think caused the problem? ______________________________

   ____

3. What does your doctor think is causing your shoulder problem? ______________________________

   ____

4. Describe your pain: ______________________________

   ____

   a) Does anything make it worse? ______________________________

   ____

   b) Does anything make it better? ______________________________

   ____

5. Do you have any weakness? __________ Where? ______________________________

   ____

6. Have you ever dislocated the shoulder being scanned today? ______________________________
7. Have you ever broken any bones in the shoulder being scanned today? ______________________________
8. Have you had surgery or arthroscopy on the area being scanned today? ______________________________

   When? ______________________________

   What was done? ______________________________

9. Do you have arthritis in any of your joints? ______________________________
10. Do you have any other medical conditions? ______________________________

    ____

    ____

11. Describe your general health: ______________________________

    ____

    ____

    ____

Please complete BOTH sides.

Patient History and Safety Screening

MRI PATIENTS ONLY

Please answer all of the following questions:

YES	NO	
☐	☐	CARDIAC PACEMAKER
☐	☐	BRAIN VESSEL CLIPS
☐	☐	AORTIC CLIPS
☐	☐	ARTIFICIAL HEART VALVE
☐	☐	CORONARY, ARTERY OR HEART SURGERY, IF YES, WHEN? ____________________
☐	☐	INSULIN PUMP
☐	☐	ELECTRODES
☐	☐	TENS UNITS OR PAIN STIMULATING UNIT
☐	☐	EAR SURGERY OR IMPLANTS
☐	☐	HEARING AIDS
☐	☐	METAL FRAGMENTS IN THE HEAD, EYE OR SKIN
☐	☐	HAVE YOU EVER WORKED WITH METAL OR AS A METAL WORKER?
☐	☐	METAL PLATES, PIN, SCREWS, NAILS OR CLIPS
☐	☐	ANY PREVIOUS SKULL SURGERY

If yes, what was the surgery for: ____

____

____

____

YES	NO	
☐	☐	IS THERE ANY CHANCE YOU ARE PREGNANT? (Not recommended for women in their first trimester of pregnancy)

Signature of patient: ____

Signature of parent or guardian: ____

Date: ______________________

Please complete BOTH sides