OCS Rehab

Patient Name: _____ Date: _____

ASES SHOULDER ASSESSMENT FORM

Age: _____
Hand Dominance: R L Ambi

Patient Self-Evaluation: Subjective Pain Description

Are you having pain in your shoulder?	Yes	No
Do you have pain in your shoulder at night?	Yes	No
Do you take pain medication (aspirin, Advil, Tylenol, etc.)?	Yes	No
Do you take narcotic pain medication (codeine or stronger)?	Yes	No

How many pills do you take each day (average)? _____ pills

How bad is your pain today?

0 No Pain	1	2	3	4	5	6	7	8	9	10 Worst Pain Imaginable

ASES Patient Self-Evaluation: Activity of Daily Living Questionnaire

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

	Right Arm	Left Arm
Put on a coat	0 1 2 3	0 1 2 3
Sleep on your painful or affected side	0 1 2 3	0 1 2 3
Wash your back or do up bra in back	0 1 2 3	0 1 2 3
Manage Toileting	0 1 2 3	0 1 2 3
Comb hair	0 1 2 3	0 1 2 3
Reach a high shelf	0 1 2 3	0 1 2 3
Lift 10 pounds above the shoulder	0 1 2 3	0 1 2 3
Throw a ball overhand	0 1 2 3	0 1 2 3
Do usual work List:	0 1 2 3	0 1 2 3
Do usual sport List:	0 1 2 3	0 1 2 3
	Total Score (R): _____	Total Score (L): _____