Shoulder Pain and Disability Index[1]

Section 1: To be completed by patient _____AD _____Non-Active Duty

Name:_____ Age:_____ Date:_____

Occupation:_____ Number of days of shoulder pain:_____(this episode)

Section 2: To be completed by patient

This questionnaire has been designed to give your therapist information as to how your shoulder pain has affected your ability to manage in every day life. For the following questions, we would like you to score each question on a scale from 0 (no pain) to 10 (worst pain imaginable) that best describes your shoulder over the past **WEEK**. Please read each question and place a number from 0-10 in the corresponding box.

Pain Scale: 0= No Pain 10=Worst Pain Imaginable

	1.	At its worst?		
	2.	When lying on the involved side?		
	3.	Reaching for something on a high self?		
	4.	Touching the back of your neck?		
	5.	Pushing with the involved arm?		

Over the last **WEEK**, how much difficulty did you have?

Disability Scale: 0= No Difficulty 10= So Difficult it Requires Help

	6.	Washing your hair?		
	7.	Washing your back?		
	8.	Putting on an undershirt or pullover/sweater?		
	9.	Putting on a shirt that buttons down the front?		
	10.	Putting on your pants?		
	11.	Placing an object on a high shelf?		
	12.	Carrying a heavy object of 10 pounds?		
	13.	Removing something from your back pocket?		

Section 3: To be completed by physical therapist/provider

SCORE:_____ **Initial** **F/U at ___ wks** **Discharge**

Number of treatment sessions:_____ **Gender:** Male Female

Diagnosis/ICD-9 Code:_____

[1] Adapted from Williams JW: Measuring function with the shoulder pain and disability index. J of Rheumatology 1995; 22:4: 727-32.