Shoulder Pain and Disability Index

Please place a mark on the line that best represents your experience during the last week attributable to your shoulder problem.

Pain Scale

How severe is your pain?

Circle the number that best describes your pain where: 0= no pain and 10= the worst pain imaginable.

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

Total pain score _____/50 x 100= _____%

(Note: If a person does not answer all questions divide by the possible score, eg. If 1 question missed divide by 40)

Disability Scale

How much difficulty do you have?

Circle the number that best describes your experience where **0**= no difficulty and **10**=so difficult it requires help.

Washing your hair?	0	1	2	3	4	5	6	7	8	9	10
Washing your back?											
Putting on an undershirt or jumper?											
Putting on a shirt that buttons down the front?											
Putting on your pants?											
Placing an object on a high shelf?											
Carrying a heavy object of 10 pounds (4.5 kilograms)											
Removing something from your back pocket?											

Total disability score: _____/80 x 100 = _____%

(Note: If a person does not answer all questions divide by the possible score, eg. If 1 question missed divide by 70)

Total Spadi score: _____ 130 x 100 _____%

(Note: If a person does not answer all questions divide by the possible score, eg If 1 question missed divide by 120)

Minimum Detectable Change (90% confidence) = 13 points

(Change less than this may be attributable to measurement error)

Source: Roach et al (1991). Development of a shoulder pain and disability index.

Olympic Physical Therapy, LLC

Patient Name:_____ **Date:**_____

Age:_____ **Height:**_____ **Weight:**_____

How much pain do you have <u>today?</u> Please circle a number (0= no pain, 10= worst pain)

0 1 2 3 4 5 6 7 8 9 10

Please list below any medications you are currently taking. Please include prescription meds, over the counter meds, and/or supplements with names, dosage, and frequency.

Drug Name	Dosage	Frequency	Drug name	Dosage	Frequency
1.			4.		
2.			5.		
3.			6.		

Have you had an injury as a result of a fall in the past year? (Please circle one): **Yes** **No**

Have you had two or more falls in the past year? **Yes** **No**

Who is your primary care physician?_____

When is the next time you are seeing a physician?_____

Have you had any diagnostic tests for this problem? **Yes** **No** (If Yes, please list below):

_____

Have you had a specific injury or surgery for this problem? **Yes** **No** (If Yes, please list below):

_____

Please list any other medical problems you have, or any other surgeries you have had?

_____

_____

Are you currently employed? **Yes** **No** **Job Title?**_____

Has your work schedule been modified because of this problem? **Yes** **No**

Are you living alone at this time? **Yes** **No**

What goal(s) would you like to accomplish with PT? _____

Please turn page over ⟶