

SHOULDER PAIN SCORE


Name _____ Number _____ Date _____

	<u>None</u>	<u>Light</u>	<u>Average</u>	<u>Severe</u>
Pain at rest	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pain in motion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nightly pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleeping problems caused by pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Incapability of lying on the painful side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	<u>None</u>	<u>Till halfway the upper arm</u>	<u>Till the elbow</u>	<u>Past the elbow</u>
Degree of radiation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Pain Scale:

Indicate on the line below the number between 0 and 100 that best describes your pain.

No pain is 0  Unbearable pain is 100