Medical Record Number

Patient Name

Addressograph or Label - Patient Name, Medical Record Number

STANFORD HOSPITAL and CLINICS
STANFORD, CALIFORNIA 94305

CLINIC REHAB MEDICAL SCREENING QUESTIONNAIRE

To help us better understand your medical history, please mark Yes or No if you have or have had the below symptoms/diagnoses and fill in all pertinent blank spaces.

Cardiovascular disease	❑ Yes ❑ No	Hepatitis	❑ Yes ❑ No
Smoking	❑ Yes ❑ No	Rheumatoid arthritis	❑ Yes ❑ No
Anemia	❑ Yes ❑ No	Osteoporosis/ Osteopenia	❑ Yes ❑ No
High cholesterol	❑ Yes ❑ No	Osteoarthritis	❑ Yes ❑ No
Emphysema or Bronchitis	❑ Yes ❑ No	Blurred vision	❑ Yes ❑ No
History of stroke or TIA	❑ Yes ❑ No	Dizziness/vertigo	❑ Yes ❑ No
Persistent cough	❑ Yes ❑ No	Double vision	❑ Yes ❑ No
Chest pain	❑ Yes ❑ No	Difficulty talking/swallowing	❑ Yes ❑ No
Shortness of breath	❑ Yes ❑ No	Headache	❑ Yes ❑ No
Asthma	❑ Yes ❑ No	Kidney disease	❑ Yes ❑ No
Tuberculosis	❑ Yes ❑ No	Immune disorder	❑ Yes ❑ No
Abdominal pain	❑ Yes ❑ No	Active Herpes, Shingles	❑ Yes ❑ No
Change in hair or nail growth	❑ Yes ❑ No	Change in bowel or bladder	❑ Yes ❑ No
Stomach ulcers	❑ Yes ❑ No	Incontinence	❑ Yes ❑ No
Fever/chills/sweats	❑ Yes ❑ No	Sudden loss of consciousness	❑ Yes ❑ No
Fatigue	❑ Yes ❑ No	Seizures	❑ Yes ❑ No
Unexplained weakness	❑ Yes ❑ No	Confusion	❑ Yes ❑ No
Unexplained weight loss/gain	❑ Yes ❑ No	Multiple sclerosis	❑ Yes ❑ No
Thyroid problems	❑ Yes ❑ No	Depression	❑ Yes ❑ No
Diabetes	❑ Yes ❑ No	Chemical dependency	❑ Yes ❑ No
Liver disease	❑ Yes ❑ No	Tingling/numbness at the inner thigh	❑ Yes ❑ No

During the past month, have you often been bothered by feeling down, depressed or hopeless?	❑ Yes ❑ No
During the past month, have you often been bothered by little interest or pleasure in doing things?	❑ Yes ❑ No
Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way?	❑ Yes ❑ No
Do you have a history of cancer?	❑ Yes ❑ No Explain:
Do you have a current infection:	❑ Yes ❑ No Explain:
Have you noticed discoloration in urine or stool?	❑ Yes ❑ No
Does eating certain foods make your pain worse?	❑ Yes ❑ No

Please complete on reverse side →

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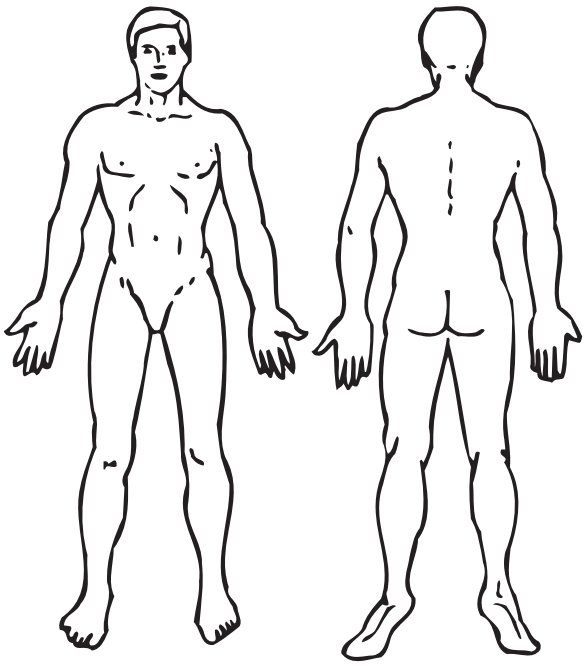
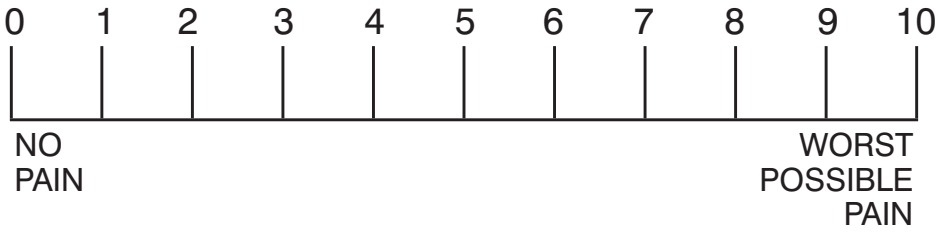
CLINIC REHAB MEDICAL SCREENING QUESTIONNAIRE

This pain drawing will help us to understand the pain that you have been experiencing. Please diagram the location of your pain.



Right Left Left Right

Please mark your current pain intensity:



DATE TIME SIGNATURE (Patient, or Properly Designated Representative)

PRINT NAME RELATIONSHIP TO PATIENT

Provider: Your signature below indicates that you have reviewed the information contained in the entire questionnaire and that you have reviewed the pertinent or key find(s) with the patient and/or family. Key finding (s) must be summarized in your progress note; however, the questionnaire should be referenced for additional details.

DATE TIME PROVIDER/TITLE PRINT NAME

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CLINICS REHAB MODIFIED ASES* QUESTIONNAIRE

INSTRUCTIONS: Please read all of the questions and circle the numerical response to the best of your ability.

#	Questions	Yes (No Trouble)	Slight Trouble	Moderate Trouble	No (I can't)
1	Can you throw a ball overhand?	3	2	1	0
2	Can you sleep on your shoulder comfortably?	3	2	1	0
3	Can you put on your coat unassisted?	3	2	1	0
4	Can you wash your back/fasten your bra?	3	2	1	0
5	Can you use toilet tissue?	3	2	1	0
6	Can you comb/wash your hair?	3	2	1	0
7	Can you lift ten **(10)** pounds (a full gallon container) above the level of your shoulder?	3	2	1	0
8	Can you reach a shelf over your head?	3	2	1	0
9	Does your shoulder allow you to work full time at your regular job (or, if not working- your regular activities)?	3	2	1	0
10	Does your shoulder allow you to do your regular sports? *Leave blank if you do not play sports.*	3	2	1	0
	Column Totals:				

On average, how much shoulder pain have you experienced in the last week?

No Pain ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ **Extreme Pain**
0 1 2 3 4 5 6 7 8 9 10

Scoring: [(Sum of Answers #1-10/3) x 5] + [(10-pain score) x 5] = Total Score ____/100

Patient Signature **Print Name** **Date** **Time**

Person completing form if other than patient **Relationship to Patient**

Instructions to Provider:
Your signature below indicates that you have reviewed the information contained in the entire questionnaire and that you have reviewed the pertinent or key finding(s) with the patient and/or family. Key finding(s) must be summarized in your progress note; however, the questionnaire should be referenced for additional details.

Provider Signature **Provider Print Name** **Date** **Time**

*ASES – American Shoulder and Elbow Surgeons

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CLINICS REHAB PATIENT-SPECIFIC FUNCTIONAL SCALE QUESTIONNAIRE

PATIENT'S NAME: _____ DATE: _____

Please identify 3 important activities that you are unable to do or are having difficulty with as a result of your pain. Use the scale immediately below the activity and rate the degree of limitation for each of the activities you list by circling one of the options:

0 – unable to perform activity
10 – able to perform activity at same activity level as before this problem

ACTIVITY #1: _____

0	1	2	3	4	5	6	7	8	9	10

ACTIVITY #2: _____

0	1	2	3	4	5	6	7	8	9	10

ACTIVITY #3: _____

0	1	2	3	4	5	6	7	8	9	10

TOTAL SCORE: Sum of activity scores/number of activities to get mean score _____/_____
MDC (90% CI) avg score = 2 points MDC (90%) CI Single activity = 3 points

Comments: _____

Patient Signature	Patient Print Name	Date	Time

Person completing form if other than patient	Relationship to Patient

Instructions to Provider:
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Provider Signature/Title	Provider Print Name	Date	Time

MDC = Minimal Detectable Change
CI = Confidence Interval