TRI-CITIES OPEN MRI

SHOULDER EXAMINATION

Patient Name _____

Patient Weight_____ Patient Height_____

Please circle: Left or Right

Please note type of symptoms you are having on the picture below,
using the following codes:

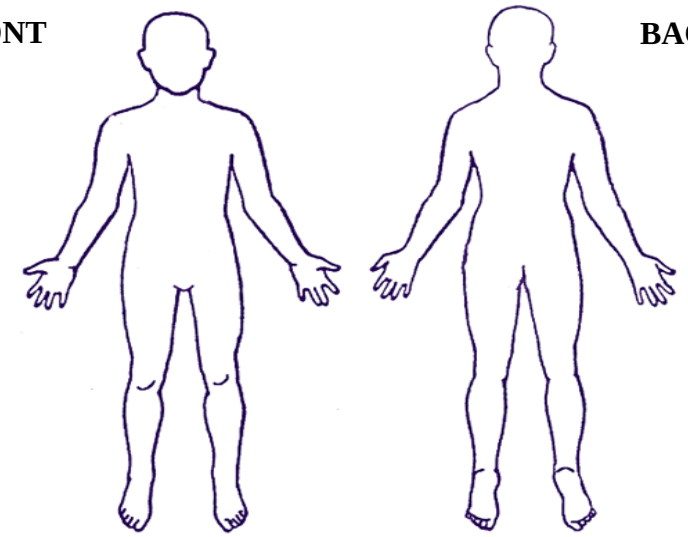
P=Pain

T=Tingling

N=Numbness

A=All

FRONT **BACK**



How long have you had this problem? _____

Have you ever dislocated your shoulder or had any instability? _____

Have you had surgery or arthroscopy on your shoulder? Please circle if yes. If yes, where and when? _____

_____

How did this condition occur? _____

Do you have trouble picking up objects or lifting arm above head? _____

Do you have loss of grip or strength? Please circle if yes.

Do you have popping, pain, catching, clicking or locking in your shoulder? Please circle if yes.

Have you had an X-ray, MRI or CT taken of the affected area in the last 5 years? Please circle if yes. If yes, where and when? _____

Comments: _____

_____ _____

Patient (Parent/Guardian) Signature Date