SHOULDER FUNCTIONAL ASSESSMENT

Instructions: The list below contains some sentences people have used to describe themselves when they have shoulder and arm pain. When your arm hurts, you may find it hard to do some of these activities. Please check only the sentences that describe your last 24 hours.

Name: _______________________________ Date: _______________________________

Affected Arm: Right [ ] Left [ ] Both [ ]

1. Because of my shoulder pain I have difficulty putting on a shirt or coat.
2. I have difficulty combing or styling my hair.
3. Because of my shoulder pain I avoid overhead activities.
4. I avoid pushing or pulling activities because of my shoulder.
5. I use a sling for my shoulder to decrease my pain.
6. I have to hold my arm next to my side due to the pain.
7. Because of my shoulder pain, I am unable to reach behind my back to strap my bra or put on my belt.
8. Because of my pain I avoid reaching in my back pocket.
9. Because of my shoulder pain I am unable to work.
10. Because of my shoulder pain I avoid or modify recreational activities.
11. When my shoulder hurts I avoid household chores.
12. I can not throw a ball without increasing my shoulder pain.
13. Resting on my shoulder for more than 5 minutes hurts my arm.
14. When I sit, I must support my arm with a pillow or arm rest.
15. When I walk, swinging my arm increases my shoulder pain.
16. My shoulder pain awakens me at least once a night.
17. Because of my shoulder pain I am unable to drive.
18. I am unable to lift objects above shoulder height.
19. Putting on a seat belt increases my shoulder pain.
20. I limit the amount of yard work I do because of my shoulder pain.
21. I can not lift a gallon of water/milk without increasing my shoulder pain.
22. Because of the pain in my shoulder I can not do a push-up.
23. Working with a computer or typewriter increases my shoulder pain.
24. I need to take medication for my shoulder pain in order to complete daily activities.
25. I think using a hammer or paint brush would increase my pain.

____ / 25 Functional Restrictions

Please mark on the line to indicate the amount of pain you have had in the past 24 hours.

**RIGHT ARM**

| No pain at all | _______________________________ | Worst pain possible |

**LEFT ARM**

| No pain at all | _______________________________ | Worst pain possible |

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**VIRGINIA THERAPY AND FITNESS CENTER**
1831 Wiehle Avenue - Second Floor - Reston, VA 20190 - 703.709.1116 - www.vtfc.com