SHOULDER PAIN AND DISABILITY QUESTIONNAIRE

Name_____ **Date**_____ **Therapist**_____

Please indicate the level of pain you are experiencing on a pain scale of: 0 - 10
0 = no pain and 10 = worst pain imaginable.

(please circle one number)

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

Please indicate the level of difficulty you have with 0 = no difficulty and 10 = so difficult it requires help.

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

Thank you for completing this questionnaire.

8/02