Ortho*Neuro* Shoulder Service
Robert J. Nowinski, DO, FAOAO
Established Patient

Name:______________________________ Date__________________
Referring Doctor:_____________________ Family Doctor:_________________________

Chief Complaint

1. Which shoulder are we evaluating you for today? Right / Left

History of Shoulder Problem

1. Have you had surgery by Dr. Nowinski? Yes / No
   If yes, list date of surgery:

2. Are you here today to review test results? Yes / No
   If yes, list which test(s) you had performed:

3. Did you have a cortisone injection performed at your last office visit? Yes / No
   If yes, did you get pain relief? Yes / No
   What percentage of pain relief did you achieve:
   How long did the injection last?

4. What medications are you currently taking for your shoulder?

5. Are you currently doing physical therapy or home exercise for your shoulder? Yes / No

6. What is the current ***severity*** of your pain? (Circle one): Mild / Moderate / Severe
   On a scale of ten, how would you rate your current pain? (Circle one number)
   (No Pain) 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 (Worst Pain Ever)

7. What is the current ***quality*** of your shoulder pain?
   Sharp / Dull / Burning / Throbbing / Constant

8. What is the current ***context*** of your symptoms? Getting better / Getting worse / Staying same

9. Are there any updates or changes to your medical history since your last office visit? Yes/No

   If yes, please list: