Shoulder Pain and Disability Index[1]

Section 1: To be completed by patient

Name:_____ Age:_____ Date:_____

Occupation:_____ Number of days of shoulder pain:_____(this episode)

Section 2: To be completed by patient

This questionnaire has been designed to give your therapist information as to how your **shoulder** has affected your ability to manage in every day life. For the following questions, we would like you to score each question on a scale from 0 (no pain or difficulty) to 10 (worst pain imaginable or so difficult it required help) that best describes your **shoulder** over the past **WEEK**. Please read each question and place a number from 0-10 in the corresponding box.

Over the last **WEEK**, how much **pain** did you have?

No Pain 0 1 2 3 4 5 6 7 8 9 10 **Worst Pain Imaginable**

1.	At its worst?		
2.	When lying on the involved side?		
3.	Reaching for something on a high self?		
4.	Touching the back of your neck?		
5.	Pushing with the involved arm?		

Over the last **WEEK**, how much **difficulty** did you have?

No Difficulty 0 1 2 3 4 5 6 7 8 9 10 **So Difficult Required Help**

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

Section 3: To be completed by physical therapist.

Subscale 1:____ Subscale 2:____ TOTAL SCORE:_____ *Initial -- F/U at ___ wks -- Discharge*

Number of treatment sessions:_____

Diagnosis/ICD-9 Code:_____

[1] Adapted from Williams JW: Measuring function with the shoulder pain and disability index. J of Rheumatology 1995; 22:4: 727-32.