

SHOULDER PAIN SCORE

Name _____ Number _____ Date _____

	<u>None</u>	<u>Light</u>	<u>Average</u>	<u>Severe</u>
Pain at rest	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pain in motion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nightly pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleeping problems caused by pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Incapability of lying on the painful side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	<u>None</u>	<u>Till halfway the upper arm</u>	<u>Till the elbow</u>	<u>Past the elbow</u>
Degree of radiation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Pain Scale:

Indicate on the line below the number between 0 and 100 that best describes your pain.

No pain is 0  Unbearable pain is 100

Reference: Winters J. C., Sobel J. S., Gronier K. H., Arendsen J.H., Meyboorn-De Jong B. A Shoulder Pain Score: A Comprehensive Questionnaire for Assessing Pain in Patients with Shoulder Complaints. Scand J Rehab Med 28:163-167. 1996

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