

WEST POINT SHOULDER EVALUATION FORM

Study ID #: _____

Today's Date: _____

Year of Graduation: _____

HISTORY OF INJURY:

Date of Initial Injury: _____

Method of Injury (circle)

Contact Sport - Contact Injury

Contact Sport - Non-Contact Injury

Non Contact Sport

Other _____

If a sport was involved, what was it? _____

Level of Competition: CORPS SQUAD CLUB INTRAMURAL "FREE TIME"

Dominant Arm: RIGHT LEFT **Shoulder Injured:** RIGHT LEFT

of Push-ups You Can Do: _____ **# Push-ups Before Injury:** _____

Sports Played Since Injury: _____

Level of Function: At Pre-Injury level Better Than Pre-Injury Level _____ % of Pre-Injury Level

of Hours per Week That You Participate in Sports / Activities: _____ hrs / wk

OVERALL FUNCTION:

On a scale from 0 – 100, how would you rate your shoulder with 100 being normal? _____

POST-OPERATIVE EVALUATION:

Date of Surgery: _____

of Months Since Surgery: _____

Type of Surgery: *(Please Circle One)*

Open Bankart Repair

Arthroscopic Bankart Repair

Open Ant./ Inf. Capsular shift

Open SLAP Repair

Arthroscopic SLAP Repair

Open Posterior Reconstruction

Arthroscopic Posterior Reconstruction

Please list all previous surgeries you have had: Date and Type of Procedure -
e.g. Right knee scope – partial meniscectomy – Oct 92

Please indicate where you spent the majority of time rehabilitating your shoulder during the following periods (i.e. Physical Therapy, DPE Training Room, ODIA Training Room, On Your Own, or No Formal rehab)

Day of Surgery thru 4 Weeks Post-op: _____

1 Month Post-op thru 3 Months Post-op: _____

4 Months Post-op thru 6 Months Post-op: _____

Courses Completed After Surgery: *(Please Circle As Many As Apply)*

BOXING

WRESTLING

CQC

GYMNASTICS

SWIMMING

IOCT

Other: _____

Since Surgery Have You Had:

Recurrent Dislocation?

Yes

No

of Months after Surgery to First Redislocation _____

of Episodes _____

Recurrent Subluxation?

Yes

No

of Months after Surgery to First Resubluxation _____

Number of Total Episodes _____

In What Activity did the First Redislocation / Resubluxation Occur? _____

COMMENTS: *(Please feel free to provide us with feedback on your care and current status)*

Western Ontario Shoulder Instability Index (WOSI)

Instructions: You are asked to indicate on this part of the questionnaire, the amount of a symptom you have experienced in the past week as related to your problematic shoulder. Simply place an “X” on the line that corresponds accurately with your symptoms. Note**

1. The further to the right you put your “X”, the **more** you experience that symptom.
2. The further left you put your “X” the **less** you experience that symptom.
3. Please do not place your “X” outside the line.
4. If you have any questions regarding the intent of any particular question, please ask.

Section A: Physical Symptoms

1. How much pain do you experience in your shoulder with overhead activities?

No
Pain

Extreme
Pain

2. How much aching or throbbing do you experience in your shoulder?

No
Aching/
Throbbing

Extreme
Aching/
Throbbing

3. How much weakness or lack of strength do you experience in you shoulder?

No
Weakness

Extreme
Weakness

4. How much fatigue of lack of stamina do you experience in your shoulder?

No
Fatigue

Extreme
Fatigue

5. How much clicking, cracking, or snapping do you experience in your shoulder?

No
Clicking

Extreme
Clicking

6. How much stiffness do you experience in your shoulder?

No
Stiffness

Extreme
Stiffness

7. How much discomfort do you experience in your neck muscles as a result of your shoulder?

No discomfort	_____	Extreme Discomfort
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8. How much feeling of instability or looseness do you experience in your shoulder?

No instability	_____	Extreme Instability
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9. How much do you compensate for your shoulder with other muscles?

Not at all	_____	Extreme
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10. How much loss of range of motion do you have in your shoulder?

No loss	_____	Extreme loss
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Section B: Sports/Recreation/Work

11. How much has your shoulder limited the amount you can participate in sports or recreational activities?

Not limited	_____	Extremely limited
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12. How much has your shoulder affected your ability to perform the specific skills required for your sport or work? (If your shoulder affects both sports and work, consider the area that is most affected.)

Not affected	_____	Extremely affected
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13. How much do you feel the need to protect your arm during activities?

Not at all	_____	Extreme
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14. How much difficulty do you experience lifting heavy objects below shoulder level?

No difficulty	_____	Extreme difficulty
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Section C: Lifestyle

15. How much fear do you have of falling on your shoulder?

No
fear

Extreme
fear

16. How much difficulty do you experience maintaining your desired level of fitness?

No
difficulty

Extreme
difficulty

17. How much difficulty do you have “roughhousing or horsing around” with family or friends?

No
difficulty

Extreme
difficulty

18. How much difficulty do you have sleeping because of your shoulder?

No
difficulty

Extreme
difficulty

Section D: Emotions

19. How conscious are you of your shoulder?

No
conscious

Extremely
conscious

20. How concerned are you about your shoulder becoming worse?

No
concern

Extremely
concerned

21. How much frustration do you feel because of your shoulder?

No
frustration

Extremely
frustrated

HEALTH STATUS QUESTIONNAIRE (SF-36)

This survey asks for your views about your health. Please answer every question by circling the appropriate number: 1,2,3, etc. If you are unsure about how to answer a question, please give it the best answer you can and make a comment in the left margin, or on the back.

1. In general, would you say your health is:

Excellent	1
Very good	2
Good	3
Fair	4
Poor	5

2. Compared to one year ago, how would you rate your health in general now?

Much better now than 1 year ago	1
Somewhat better now than 1 year ago	2
About the same	3
Somewhat worse now than 1 year ago	4
Much worse now than 1 year ago	5

3. The following questions are about activities you might do during a typical day.

	Yes, Limited a Lot	Yes, Limited a Little	No, Not Limited at All
a. Vigorous activities, such as running, lifting heavy objects, participating in strenuous sports	1	2	3
b. Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	1	2	3
c. Lifting or carrying groceries	1	2	3
d. Climbing several flights of stairs	1	2	3
e. Climbing one flight of stairs	1	2	3
f. Bending, kneeling, or stooping	1	2	3
g. Walking more than 1 mile	1	2	3
h. Walking several blocks	1	2	3
i. Walking one block	1	2	3
j. Bathing and dressing yourself	1	2	3

4. During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

	Yes	No
a. Cut down on the amount of time you spent on work or other activities	1	2
b. Accomplished less than you would like	1	2
c. Were limited in the kind of work or other activities	1	2
d. Had difficulty performing the work or other activities (e.g., it took extra effort)	1	2

5. During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (e.g., feeling depressed or anxious)?

	Yes	No
a. Cut down on the amount of time you spent on work or other activities	1	2
b. Accomplished less than you would like	1	2
c. Didn't do work or other activities as carefully as usual	1	2

6. During the past 4 weeks, to what extent have your physical health or emotional problems interfered with your normal social activities with family, friends, neighbors, or groups?

Not at all	1
Slightly	2
Moderately	3
Quite a bit	4
Extremely	5

7. How much body pain have you had during the past 4 weeks?

None	1
Very mild	2
Mild	3
Moderate	4
Severe	5
Very severe	6

8. During the past 4 weeks, how much did pain interfere with your normal work (including work both outside the home and housework)?

Not at all	1
A little	2
Moderately	3
Quite a bit	4
Extremely	5

9. These questions are about how you feel and how things have been with you during the past month. For each question, please indicate the one answer that comes closest to the way you have been feeling. How much of the time during the past month

	All of the Time	Most of the Time	A Good Bit of the Time	Some of the Time	A Little of the Time	None of the Time
a. Did you feel full of pep?	1	2	3	4	5	6
b. Have you been a very nervous person?	1	2	3	4	5	6
c. Have you felt so down in the dumps nothing could cheer you up?	1	2	3	4	5	6
d. Have you felt calm and peaceful?	1	2	3	4	5	6
e. Did you have a lot of energy?	1	2	3	4	5	6
f. Have you felt downhearted and blue?	1	2	3	4	5	6
g. Did you feel worn out?	1	2	3	4	5	6
h. Have you been a happy person?	1	2	3	4	5	6
i. Did you feel tired/	1	2	3	4	5	6
j. Has your health limited your social activities (like visiting your friends or close relatives)?	1	2	3	4	5	6

10. Please choose the answer that best describes how true or false each of the following statements is for you.

	Definitely True	Mostly True	Not Sure	Mostly False	Definitely False
a. I seem to get sick a little easier than other people	1	2	3	4	5
b. I am as healthy as anybody I know	1	2	3	4	5
c. I expect my health to get worse	1	2	3	4	5
d. My health is excellent	1	2	3	4	5

11. Please answer YES or NO for each question by circling 1 or 2 on each line.

	Yes	No
a. In the past year, have you had 2 weeks or more during which you felt sad, blue, or depressed; or when you lost all interest or pleasure in things you usually care about or enjoyed?	1	2
b. Have you had 2 years or more in your life when you felt depressed or sad most days, even if you felt okay sometimes?	1	2
c. Have you felt depressed or sad much of the time in the past year?	1	2

ROWE SCORE:

* **I. Please circle the letter of the statement that best describes the FUNCTION of your shoulder:**

- a. I perform all my work and sports; I have no limitation in overhead activities, my shoulder is strong in lifting, swimming, tennis, throwing; I have no discomfort. 30
- b. I have mild limitations in work and sports. My shoulder is strong. I have minimum discomfort. 25
- c. I have moderate limitations doing overhead work and heavy lifting; I am unable to throw, serve hard in tennis, or swim; I have “moderate disabling” pain. 10
- d. I have marked limitations. I am unable to perform overhead work and lifting; I cannot throw, play tennis, or swim. I have “chronic discomfort”. 0

Total ROWE Score (see also PT form): _____ (100)

SIMPLE SHOULDER TEST – (Simply circle yes or no)

- | | | |
|---|-----|----|
| 1. Is your shoulder comfortable with your arm at rest by your side? | Yes | No |
| 2. Does your shoulder allow you to sleep comfortably? | Yes | No |
| 3. Can you reach the small of your back to tuck in your shirt with your hand? | Yes | No |
| 4. Can you place your hand behind your head with the elbow straight out to the side? | Yes | No |
| 5. Can you place a coin on a shelf at the level of your shoulder without bending your elbow? | Yes | No |
| 6. Can you lift 1 lb (a full pint container) to the level of your shoulder without bending your elbow? | Yes | No |
| 7. Can you lift 8 lb (a full gallon container) to the level of the top of your head without bending your elbow? | Yes | No |
| 8. Can you carry 20 lb (a bag of potatoes) at your side with the affected extremity? | Yes | No |
| 9. Do you think you can toss a softball underhand 10 yards with the affected extremity? | Yes | No |
| 10. Do you think you can throw a softball overhand 20 yards with the affected extremity? | Yes | No |
| 11. Can you wash the back of your opposite shoulder with the affected extremity? | Yes | No |
| 12. Would your shoulder allow you to work full-time at your regular job? | Yes | No |

Tegner Activity Score

Circle the number which best corresponds to your current activity level. **Circle only one number.** Put an X next to the number that corresponds to your pre-injury activity level.

10. Competitive sports
Soccer-national and international elite
9. Competitive sports
Soccer, lower divisions
Ice hockey, Wrestling, Gymnastics
8. Competitive sports
Bandy, Squash or badminton
Athletics (jumping, etc.)
Downhill skiing
7. Competitive sports
Tennis, Handball
Athletics (running)
Motorcross, speedway
Basketball
Recreational sports
Soccer, Squash
Bandy and ice hockey
Athletics (jumping)
Cross-country track findings both recreational and competitive
6. Recreational sports
Tennis and badminton
Handball
Basketball
Downhill skiing
Jogging, at least five times per week
5. Work – heavy labor (e.g., building, forestry)
Competitive sports
Cycling
Cross-country skiing
Recreational sports
Jogging on uneven ground at least twice weekly
4. Work – Moderately heavy labor (e.g., truck driving, heavy domestic work)
Recreational sports
Cycling
Cross-country skiing
Jogging on even ground at least twice weekly
3. Work – Light labor (e.g., nursing)
Competitive and recreational sports - swimming
2. Work – Light labor
Walking on uneven ground possible but impossible to walk in forest
1. Work – Sedentary work
Walking on even ground possible
0. Sick leave or disability pension because of knee/shoulder problems

ASES SCORING SYSTEM

Are you having pain in your shoulder?	YES	NO																						
Do you have pain in your shoulder at night?	YES	NO																						
Do you take pain medication (aspirin, Tylenol, Advil, etc...)?	YES	NO																						
Do you take narcotic pain medication (codeine or stronger)?	YES	NO																						
How many pills do you take each day (average)?	pills																							
How bad is your pain today (mark line)?																								
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0										10														
No pain at all										Pain as bad as it can be														

Does your shoulder feel unstable (as if is going to dislocate)?	YES	NO																						
How unstable is your shoulder (mark line)?																								
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0										10														
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**Circle the number in the box that indicates your ability to do the following activities:
0 = unable to do; 1 = very difficult to do; 2 = somewhat difficult; 3 = not difficult**

Activity	Right Arm	Left Arm
1. Put on a coat	0 1 2 3	0 1 2 3
2. Sleep on your painful or affected side	0 1 2 3	0 1 2 3
3. Wash back or do up bra in back	0 1 2 3	0 1 2 3
4. Manage toileting	0 1 2 3	0 1 2 3
5. Comb hair	0 1 2 3	0 1 2 3
6. Reach a high shelf	0 1 2 3	0 1 2 3
7. Lift 10 lb above the shoulder	0 1 2 3	0 1 2 3
8. Throw a ball overhand	0 1 2 3	0 1 2 3
9. Do usual work – list:	0 1 2 3	0 1 2 3
10. Do usual sport – list:	0 1 2 3	0 1 2 3