

SHOULDER PAIN SCORE

Name _____ Number _____ Date _____

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

	<u>None</u>	<u>Till halfway the upper arm</u>	<u>Till the elbow</u>	<u>Past the elbow</u>
Degree of radiation				

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