SHOULDER JOINT PAIN ASSESSMENT

Date: _____
Patient Name:
DOB:

1. Pain Intensity (VAS)

Circle level of pain: (0 = None, 10 = Emergency)

0
1
2
3
4
5
6
7
8
9
10

2. Affected Side & Location

Left Shoulder Right Shoulder Bilateral

Primary pain site: (e.g., Anterior, Lateral, Posterior, Deep joint)

3. Functional Range of Motion

Movement	Limited?	Painful?
Flexion (Reaching up)	â–¡	â–¡
Abduction (Side lift)	â–¡	â–¡
Internal Rotation (Behind back)	â–¡	â–¡

Movement	Limited?	Painful?
External Rotation (Behind neck)	â–¡	â–¡

4. Qualitative Assessment

Sharp / Stabbing	Dull / Aching	Burning
Clicking / Popping	Instability	Night Pain

Clinical Notes & Observations

Clinician Signature: _____ Date: _____