

Industrial Physical Therapy, Inc.

Shoulder Pain And Disability Index

Name: _____ **Signature:** _____ **Date:** _____

Pain Scale: Circle the number to show how much PAIN you have had in the past week for each question. How severe is your pain:

1. At it's worst?

No pain at all 0 1 2 3 4 5 6 7 8 9 10 Worst pain imaginable

2. When lying on the involved side?

No pain at all 0 1 2 3 4 5 6 7 8 9 10 Worst pain imaginable

3. Reaching for something on a high shelf?

No pain at all 0 1 2 3 4 5 6 7 8 9 10 Worst pain imaginable

4. Touching the back of your neck?

No pain at all 0 1 2 3 4 5 6 7 8 9 10 Worst pain imaginable

5. Pushing with the involved arm?

No pain at all 0 1 2 3 4 5 6 7 8 9 10 Worst pain imaginable

Disability Scale: Circle the number to show how much DIFFICULTY you have had in the past week to do the activities listed below. How much difficulty do you have?

1. Washing your hair?

No difficulty 0 1 2 3 4 5 6 7 8 9 10 So difficult it required help

2. Washing your back?

No difficulty 0 1 2 3 4 5 6 7 8 9 10 So difficult it required help

3. Putting on an undershirt or pullover shirt?

No difficulty 0 1 2 3 4 5 6 7 8 9 10 So difficult it required help

4. Putting on a shirt that buttons down the front?

No difficulty 0 1 2 3 4 5 6 7 8 9 10 So difficult it required help

5. Putting on your pants?

No difficulty 0 1 2 3 4 5 6 7 8 9 10 So difficult it required help

6. Placing an object on a high shelf?

No difficulty 0 1 2 3 4 5 6 7 8 9 10 So difficult it required help

7. Carrying a heavy object of 10 pounds?

No difficulty 0 1 2 3 4 5 6 7 8 9 10 So difficult it required help

8. Removing something from your back pocket?

No difficulty 0 1 2 3 4 5 6 7 8 9 10 So difficult it required help