# SHOULDER PAIN SCORE

Name _______________________________________ Number __________ Date ______________

<table>
<thead>
<tr>
<th>None</th>
<th>Light</th>
<th>Average</th>
<th>Severe</th>
</tr>
</thead>
</table>

**Pain at rest**

**Pain in motion**

**Nightly pain**

**Sleeping problems caused by pain**

**Incapability of lying on the painful side**

<table>
<thead>
<tr>
<th>None</th>
<th>Till halfway the upper arm</th>
<th>Till the elbow</th>
<th>Past the elbow</th>
</tr>
</thead>
</table>

**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


FORM 507