

SHOULDER PAIN AND DISABILITY INDEX

Name: _____ Date: ___/___/___

Rate the severity of pain you experience as such:

On a scale of 0-10: 0= no pain 10= the worst or severe pain

When it is at its worst:	0 1 2 3 4 5 6 7 8 9 10
When lying on the involved side:	0 1 2 3 4 5 6 7 8 9 10
When reaching for an item on a high shelf:	0 1 2 3 4 5 6 7 8 9 10
When touching the back of your neck:	0 1 2 3 4 5 6 7 8 9 10
When pushing with the involved arm:	0 1 2 3 4 5 6 7 8 9 10

Rate how difficult it is to do the following activities:

On a scale of 0-10: 0= no difficulty 10= so difficult it requires help

Washing your hair:	0 1 2 3 4 5 6 7 8 9 10
Washing your back:	0 1 2 3 4 5 6 7 8 9 10
Putting on an undershirt or pull over sweater.	0 1 2 3 4 5 6 7 8 9 10
Putting on a shirt that buttons down the front:	0 1 2 3 4 5 6 7 8 9 10
Putting on pants:	0 1 2 3 4 5 6 7 8 9 10
Placing an object on a high shelf:	0 1 2 3 4 5 6 7 8 9 10
Carrying a heavy object of 10 pounds:	0 1 2 3 4 5 6 7 8 9 10
Removing something from your back pocket:	0 1 2 3 4 5 6 7 8 9 10

*******(For Therapist Use Only)*******

Score: _____% (MCID= 13 points) Pain Score: _____% Disability Score: _____%