KSPS Questionnaire

Please circle or write responses as indicated. Please answer each question as accurately as possible.

|  |  |  |
| --- | --- | --- |
| **D.O.B.****Gender:** | **Height:****Weight:** | **BMI:** |
| **Which hand do you write with?** RIGHT / LEFT**Which hand do you throw a ball with?** RIGHT / LEFT |
| **Current employment:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Does your job require regular overhead movements or heavy lifting?** YES / NO |
| **Level of activity at work (please tick):** | Inactive | □ |
| Moderately active | □ |
| Extremely active | □ |
| Manual labour | □ |
| **Do you play an overhead sport?** YES / NO**Do you play a contact sport?** YES / NO**Sport and exercise (please list):**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Hours per week:** \_\_\_\_\_\_\_\_\_ hours |
| **Current level of sports competition (please tick):** | None | □ |
| Social | □ |
| Club | □ |
| Elite | □ |
| Professional | □ |
| **If applicable, is your current level of competition the same as prior to your shoulder injury / surgery? Please specify.**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Do you have any current medical conditions or injuries?** YES / NO**If YES, please list:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Are you currently taking any medication (including vitamins and supplements)?** YES / NO**If YES, please list:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Have you ever had a shoulder injury that required medical or surgical treatment or forced you to change your normal daily activities?** YES / NO |
| **PARTICIPANTS *WITHOUT* SHOULDER INJURIES, PLEASE PROCEED TO THE END OF THE QUESTIONNAIRE.PARTICIPANTS *WITH* SHOULDER INJURIES OR PAST SURGERY, PLEASE COMPLETE ALL THE SECTIONS.** |

|  |
| --- |
| **What was the nature of your injury?** DISLOCATION / SUBLUXATION / OTHER**If “other” please describe:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**How long ago did your injury occur?**LESS THAN 4 MONTHS / 4 TO 8 MONTHS / LONGER THAN 8 MONTHS |
| **Do you intend to return to your pre-injury level of sport and exercise?** YES / NO |
| **Have you ever had shoulder surgery?** YES / NO | **If YES, which arm?** RIGHT / LEFT / BOTH**When did you have surgery? ­­**\_\_ / \_\_ / \_\_\_ **Where there any complications?** YES / NO**Please describe the complications: \_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **If NO, do you intend to have shoulder surgery?** YES / NO**If NOT, please briefly describe why:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Have you had any non-surgical treatment for your shoulder (physiotherapy, myotherapy, acupuncture, etc.)?** YES / NO | **If YES, please list:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **If NO, do you intend to have treatment for your shoulder?** YES / NO**If NOT, please describe why:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **How severe is the pain in your shoulder right now?** NONE / MILD / MODERATE / SEVERE**Do you take any pain killer pills for your shoulder pain?** YES / NO\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**How many pills do you take each day?** \_\_\_\_\_\_\_\_\_\_\_ |

# Oxford Stability Score 12 Item Questionnaire

Please circle one option per question.

|  |
| --- |
| 1. During the last 6 months, how many times has your shoulder slipped out of joint (or dislocated)?
 |
| Not at all | 1 or 2 times in 6 months | 1 or 2 times a month | 1 or 2 times per week | More than 1 or 2 times per week |
| 1. During the last 3 months, have you had any trouble (or worry) dressing because of your shoulder?
 |
| No trouble at all | Slight trouble | Moderate trouble | Extreme difficulty | Impossible to do |
| 1. During the last 3 months, how would you describe the worst pain you have had from your shoulder?
 |
| None | Mild ache | Moderate | Severe | Unbearable |
| 1. During the last 3 months, how much has the problem with your shoulder interfered with your usual work?
 |
| Not at all | A little bit | Moderately | Greatly | Totally |
| 1. During the last 3 months have you avoided any activities due to worry about your shoulder (feared that it might slip out of joint)?
 |
| Not at all | Very occasionally | Some days | Most days or more than one activity | Every day or many activities |
| 1. During the last 3 months, has the problem with your shoulder prevented you from doing things that are important to you?
 |
| Not at all | Very occasionally | Some days | Most days or more than one activity | Every day or many activities |
| 1. During the last 3 months, how much has the problem of your shoulder interfered with your social life?
 |
| Not at all | Occasionally | Some days | Most days | Every day |
| 1. During the last 4 weeks, how much has the problem with your shoulder interfered with your sports or hobbies?
 |
| Not at all | A little/occasionally | Some of the time | Most of the time | All of the time |
| 1. During the last 4 weeks, how often has your shoulder been ‘on your mind’ – how often have you thought about it?
 |
| Never, only if someone asks | Occasionally | Some days | Most days | Every day |
| 1. During the last 4 weeks, how much has the problem with your shoulder interfered with your ability to lift heavy objects?
 |
| Never, only if someone asks | Occasionally | Some days | Most days | Every day |
| 1. During the last 4 weeks, how would you describe the pain you usually get from your shoulder?
 |
| None | Very mild | Mild | Moderate | Severe |
| 1. During the last 4 weeks, have you avoided lying in certain positions in bed at night because of your shoulder?
 |
| No | Only 1 or 2 nights | Some nights | Most nights | Every night |

# Original Rowe Score

Please tick one box per section.

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| --- |
| Section 1 – Stability |
| □ | No recurrence, subluxation or apprehension | 50 |
| □ | Apprehension when placing arm in certain positions | 30 |
| □ | Subluxation (not requiring reduction) | 10 |
| □ | Recurrent dislocation | 0 |
| Section 2 – Motion |
| □ | 100% of normal external rotation, internal rotation and elevation | 20 |
| □ | 75% of normal external rotation, internal rotation and elevation | 15 |
| □ | 50% of normal external rotation, internal rotation and elevation | 5 |
| □ | 50% of normal elevation and internal rotation, NO external rotation | 0 |
| Section 3 – Function |
| □ | No limitation of work or sports, little or no discomfort (e.g. shoulder strong overhead, lifting, swimming, throwing, tennis) | 30 |
| □ | Mild limitation and minimum discomfort | 25 |
| □ | Moderate limitation and discomfort | 10 |
| □ | Marked limitation and pain | 0 |