

INSTRUCTIONS FOR THE:



SHOULDER PAIN AND DISABILITY INDEX (SPADI)

This questionnaire has been designed to give your therapist information as to how your shoulder pain has affected your ability to manage in every day life. Please answer every question. For each of the following questions, we would like you to score each question on a scale from 0 (no pain or difficulty) to 10 (worst pain imaginable or so difficult it required help) that best describes your shoulder over the past WEEK. Please read each question and place a number from 0-10 in the corresponding box.

EXAMPLE:

Over the last <u>WEEK</u> , how much pain did you have?												
No Pain	0	1	2	3	4	5	6	7	8	9	10	Worst Pain Imaginable
1.	At its worst?										4	



Shoulder Pain and Disability Index

Section 1: To be completed by patient _____ AD _____ Non-Active Duty

Name: _____ Age: _____ Date: _____

Occupation: _____ Number of days of shoulder pain: _____ (this episode)

Section 2: To be completed by patient

Over the last **WEEK**, how much **pain** did you have?

No Pain 0 1 2 3 4 5 6 7 8 9 10 **Worst Pain Imaginable**

	1.	At its worst?		
	2.	When lying on the involved side?		
	3.	Reaching for something on a high shelf?		
	4.	Touching the back of your neck?		
	5.	Pushing with the involved arm?		

Over the last **WEEK**, how much **difficulty** did you have?

No Difficulty 0 1 2 3 4 5 6 7 8 9 10 **So Difficult Required Help**

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

Section 3: To be completed by physical therapist/provider

SCORE:

Initial: Subscale 1: _____ Subscale 2: _____ TOTAL: _____

F/U 1: Subscale 1: _____ Subscale 2: _____ TOTAL: _____ **F/U 2:** Subscale 1: _____ Subscale 2: _____ TOTAL: _____

D/C: Subscale 1: _____ Subscale 2: _____ TOTAL: _____

Diagnosis/ICD-9 Code: _____ **Number of treatment sessions:** _____