



**Part 1: The SIS - Shoulder Impairment Scale** – after Dr Josh Wies PhD

**TO BE COMPLETED AFTER YOUR LAST TREATMENT (or when advised by your therapist)**

**Please complete the following to the best of your ability:**

**Name:** -----

**Gender:** -----

**Age:** -----

**Date of Birth:** -----

**Handiness (circle):** Right / Left / Ambidextrous

**Occupation:** -----

**How many weeks ago did your current shoulder problem start:** -----

**Do you have any current or past medical problems (circle):**

Heart / Blood Pressure / Breathing Difficulty / Rheumatoid Arthritis / Pregnancy / Osteoporosis /

Broken Bone / Unexplained Weight Loss / Skin Problems / Seizures / Neurological Disorder /

Blood Thinners /Other: -----

**How would you rate your general health (circle):**

Poor / Fair / Good / Excellent

**Have you had any diagnostic tests of the shoulder? (circle):**

X-ray / CT Scan / MRI / Arthrogram / Nerve Conduction Test /Other:

**Prior episodes of shoulder problems (circle):** Yes / No

**Please list medications you are currently taking:** -----

**Please rate your level of pain NOW on a scale from 0 to 10, where 0 is no pain at all and 10 is the worst it can be.**

**(Now)** 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

**Irritating Factors: What activities or positions increase your pain?** -----

**Alleviating Factors: What activities or positions relieve your pain?** -----



## Shoulder Pain and disability Index (SPADI)

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### Disability scale: How much difficulty do you have....

0 = no difficulty    10 = unable to do    N/A = not applicable

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?



## Part 2: About Your Treatment

TO BE COMPLETED AFTER YOUR LAST TREATMENT (or when advised by your therapist)

How many months had you been suffering with your frozen shoulder: .....

How many treatment sessions did you have: .....

Was the treatment effective: .....

Did you try any other therapies before the Niel-Asher Technique™: .....

Which ones: .....

Were they effective: .....

Did you try any other therapies whilst undergoing the Niel-Asher Technique™: .....

Which ones: .....

Were they effective: .....

### About your therapist

What was the name of your therapist: .....

Were you happy with your therapist: .....

How did you find your therapist (please circle):

www.frozenshoulder.com / Recommendation / Doctor / Consultant / Newspaper or Media

If Newspaper or Media, what was the publications name: .....

### Testimonial

If you would like to write a letter of testimonial for your therapist, please attach and send with this form.

**Welcome pack**  
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