Shoulder Pain and Disability Index (SPADI)

Name: ____________________________ Date of Birth: ___ / ___ / ____ MR#____________________

Mark each section by circling the number that best describes your problem.

**Pain scale**

**How severe is your pain?**

(0 = no pain  10 = worst pain imaginable  NA = not applicable)

1. At its worst? 0 1 2 3 4 5 6 7 8 9 10 NA
2. When lying on the involved side? 0 1 2 3 4 5 6 7 8 9 10 NA
3. Reaching for something on a high shelf? 0 1 2 3 4 5 6 7 8 9 10 NA
4. Touching the back of your neck? 0 1 2 3 4 5 6 7 8 9 10 NA
5. Pushing with the involved arm? 0 1 2 3 4 5 6 7 8 9 10 NA

**Disability scale**

**How much difficulty do you have?**

(0 = no difficulty  10 = so difficult it required help  NA = not applicable)

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

Patient Signature: ____________________________ Date: ______ Time: ______