

Western Ontario Shoulder Instability Index (WOSI)

Instructions: You are asked to indicate on this part of the questionnaire, the amount of a symptom you have experienced in the past week as related to your problematic shoulder. Simply place an "X" on the line that corresponds accurately with your symptoms.

Note**

1. The further to the right you put your "X", the **more** you experience that symptom.
2. The further left you put your "X" the **less** you experience that symptom.
3. Please do not place your "X" outside the line.
4. If you have any questions regarding the intent of any particular question, please ask.

Section A: Physical Symptoms

1. How much pain do you experience in your shoulder with overhead activities?

No Pain	Extreme Pain
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2. How much aching or throbbing do you experience in your shoulder?

No Aching/ Throbbing	Extreme Aching/ Throbbing
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3. How much weakness or lack of strength do you experience in you shoulder?

No Weakness	Extreme Weakness
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4. How much fatigue of lack of stamina do you experience in your shoulder?

No Fatigue	Extreme Fatigue
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5. How much clicking, cracking, or snapping do you experience in your shoulder?

No Clicking	Extreme Clicking
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6. How much stiffness do you experience in your shoulder?

No Stiffness	Extreme Stiffness
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7. How much discomfort do you experience in your neck muscles as a result of your shoulder?

No Discomfort	Extreme Discomfort
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8. How much feeling of instability or looseness do you experience in your shoulder?

No Instability	Extreme Instability
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9. How much do you compensate for your shoulder with other muscles?

Not at all	Extreme
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10. How much loss of range of motion do you have in your shoulder?

No Loss	Extreme loss
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Section B: Sports/Recreation/Work

11. How much has your shoulder limited the amount you can participate in sports or recreational activities?

Not Limited	Extremely limited
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12. How much has your shoulder affected your ability to perform the specific skills required for your sport or work? (If your shoulder affects both sports and work, consider the area that is most affected.)

Not Affected	Extremely affected
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13. How much do you feel the need to protect your arm during activities?

Not at all	Extreme
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14. How much difficulty do you experience lifting heavy objects below shoulder level?

No Difficulty	Extreme difficulty
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Section C: Lifestyle

15. How much fear do you have of falling on your shoulder?

No Fear	Extreme fear
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16. How much difficulty do you experience maintaining your desired level of fitness?

No Difficulty	Extreme difficulty
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17. How much difficulty do you have “roughhousing or horsing around” with family or friends?

No Difficulty	Extreme difficulty
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18. How much difficulty do you have sleeping because of your shoulder?

No Difficulty	Extreme difficulty
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Section D: Emotions

19. How conscious are you of your shoulder?

Not Conscious	Extremely conscious
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20. How concerned are you about your shoulder becoming worse?

No Concerned	Extremely concern
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21. How much frustration do you feel because of your shoulder?

No Frustrated	Extremely frustrated
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