

Date: ___/___/___ Name: _____ Age: ___ Male Female
Referred by: _____ Date of Injury: _____
Medications: _____ Allergies: _____ or circle NONE

SINCE LAST VISIT
Symptoms have...? Improved Not Changed Increased
My current work status...? Full Duty Light Duty Not able to work

SYMPTOMS
1. Is your shoulder comfortable at your side? Yes No
2. Does your shoulder allow you to sleep comfortably? Yes No
3. Can you reach the small of your back to tuck in your shirt? Yes No
4. Can you place your hand behind your head with the elbow straight out to the side? Yes No
5. Can you place a coin on a shelf at shoulder level without bending your elbow? Yes No
6. Can you lift 1lb (a full pint container) to shoulder level without bending your elbow? Yes No
7. Can you lift 8lbs (a full gallon container) to shoulder level without bending your elbow? Yes No
8. Can you carry 20lbs at your side with the affected extremity? Yes No
9. Do you think you can toss a softball underhand 10 yards with the affected extremity? Yes No
10. Do you think that you can toss a softball overhand 20 yards with the affected extremity? Yes No
11. Can you wash the back of your opposite shoulder with the affected extremity? Yes No
12. Would your shoulder allow you to work a full time job at your regular job? Yes No

ACTIVITY
1. Are you receiving physical therapy? Yes No
2. Do symptoms allow you to play sports? Yes No
3. Are you working? Yes No Full Duty Light Duty

FUNCTION
1. How would you rate your overall level of pain?
None... 1 2 3 4 5 6 7 8 9 10 ...Disabling
2. How would you rate your shoulder comfort with arm at rest?
None... 1 2 3 4 5 6 7 8 9 10 ...Painful
3. How would you rate your shoulder comfort during sleep?
None... 1 2 3 4 5 6 7 8 9 10 ...Wakes me up
4. How would you rate your overall level of shoulder function?
Comfortable... 1 2 3 4 5 6 7 8 9 10 ...Unable to use
5. How would you rate your ability to use your arm full time at work or play?
No Problem... 1 2 3 4 5 6 7 8 9 10 ...Unable to use
6. How would you rate your overall quality of life as is with your shoulder injury?
Very Good... 1 2 3 4 5 6 7 8 9 10 ...Very Bad

Do you play sports? Yes No Baseball Basketball Football Soccer Other: _____
What position do you play? _____ At which school? _____

FOLLOW UP SHOULDER EXAMINATION PATIENT: _____ DATE: ___/___/___

TENDERNESS: AC Joint Ant Acromion Post Acromion Coracoid Bicipital Groove

RANGE OF MOTION: Full

PATIENT SITTING	[R]	[L]	PATIENT SUPINE	[R]	[L]
Active Horizontal Abduction	----	----	Passive Horizontal Abduction	----	----
Active Forward Flexion	----	----	Passive External Rotation	----	----
Active External Rotation	----	----			
Passive External Rotation	----	----			
Passive Internal Rotation	----	----			
Scapular Motion			<input type="checkbox"/> Synchronous	<input type="checkbox"/> Asynchronous	

STRENGTH

Deltoid	_____/5	<input type="checkbox"/> Pain	Biceps	_____/5	<input type="checkbox"/> Pain
Scaption	_____/5	<input type="checkbox"/> Pain	Triceps	_____/5	<input type="checkbox"/> Pain
Lift Off	_____/5	<input type="checkbox"/> Pain	Wrist Extension	_____/5	<input type="checkbox"/> Pain
External Rotation	_____/5	<input type="checkbox"/> Pain	Wrist Flexion	_____/5	<input type="checkbox"/> Pain
Internal Rotation	_____/5	<input type="checkbox"/> Pain	Finger Abduction	_____/5	<input type="checkbox"/> Pain

STABILITY:

	Normal	Apprehension	Subluxation	Relocation
Anterior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> (+) <input type="checkbox"/> (-)
Posterior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> (+) <input type="checkbox"/> (-)
Inferior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> (+) <input type="checkbox"/> (-)

IMPINGEMENT SIGNS: Normal

NEER HAWKINS JOBE SPEED O'BRIEN SLAP TEST

CERVICAL SPINE EXAM: Normal

			SENSORY	(N) (↓'D)	SENSORY	(N) (↓'D)
Range of Motion	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal_____	C-1	<input type="checkbox"/> <input type="checkbox"/>	C-6	<input type="checkbox"/> <input type="checkbox"/>
Head Compression	<input type="checkbox"/> Negative	<input type="checkbox"/> Positive	C-2	<input type="checkbox"/> <input type="checkbox"/>	C-7	<input type="checkbox"/> <input type="checkbox"/>
Foraminal Closure	<input type="checkbox"/> Negative	<input type="checkbox"/> Positive	C-3	<input type="checkbox"/> <input type="checkbox"/>	C-8	<input type="checkbox"/> <input type="checkbox"/>
			C-4	<input type="checkbox"/> <input type="checkbox"/>	T-1	<input type="checkbox"/> <input type="checkbox"/>
			C-5	<input type="checkbox"/> <input type="checkbox"/>		

X-RAYS: Normal None Taken Shows: DJD AC Arthritis

MRI Shows: SLAP Labral Tear RCT Biceps Tear/Rupture

IMPRESSION: <input type="checkbox"/> AC DJD <input type="checkbox"/> Calcific Tendonitis <input type="checkbox"/> Subluxation: Post / Ant <input type="checkbox"/> AC Separation (___) <input type="checkbox"/> DJD <input type="checkbox"/> RCT <input type="checkbox"/> Adhesive Capsulitis <input type="checkbox"/> Impingement <input type="checkbox"/> SLAP <input type="checkbox"/> Ant Subluxation <input type="checkbox"/> Instability <input type="checkbox"/> Other: _____	Status Post: <input type="checkbox"/> RCR <input type="checkbox"/> SLAP/Labral Repair <input type="checkbox"/> Bankart
--	---

PLAN: Observation Injection _____ Medication(s): _____

Aspiration Lab Exam Other: _____

Patient will call to report progress If no changes in improvement order an MRI

PHYSICAL THERAPY: RC Strengthening Scapular Stabilization SLAP Protocol Bankart Protocol

Throwing Program RCR Protocol Other: _____

IMAGING: MRI: _____ with IAGAG Other: _____

Surgical Procedure: _____

RTC: _____ weeks / months RTW Status: No Work Light Duty Full Duty

COMMENTS: _____