

## Physical Evaluation Form

Name:

Date:

Age: Hand dominance: R L Ambi

Gender: M F

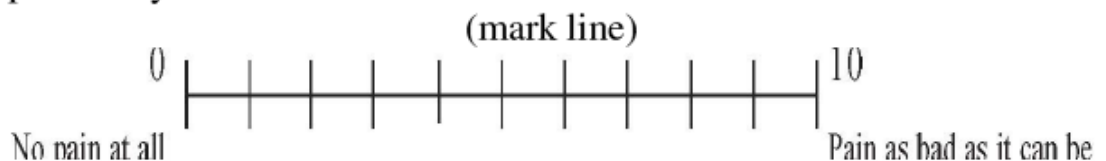
Diagnosis: Initial Assess? Y N

Which shoulder is painful? L R Both

## SHOULDER SELF-EVALUATION

- Are you having pain in your shoulder? (circle the correct answer) Yes No
- Mark where your pain is:
- Do you have pain in your shoulder at night? Yes No
- Do you take pain medication? (aspirin, Advil, etc) Yes No
- Do you take prescription pain medication? Please list: Yes No
- How many pills do you take each day (average)? Pills
- How bad is your pain today? (mark line)

How bad is your pain today?

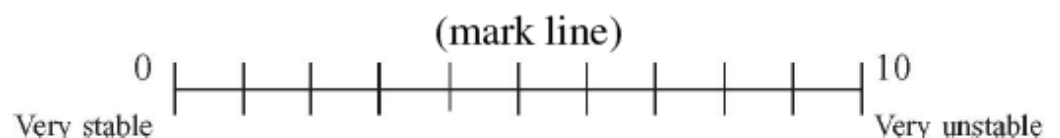


- Does your shoulder feel unstable (as if it is going to dislocate)? Yes No
- How unstable is your shoulder? (mark line)

Circle the number in the box that indicates your ability to do the following activities:

0 = Unable to do; 1 = very difficult to do; 2 = somewhat difficult; 3 = not difficult

How unstable is your shoulder?



## ACTIVITY RIGHT ARM LEFT ARM

- Put on a coat 0 1 2 3 0 1 2 3
- Sleep on your painful or affected side 0 1 2 3 0 1 2 3
- Wash back/do up bra in back 0 1 2 3 0 1 2 3
- Manage toileting 0 1 2 3 0 1 2 3
- Comb hair 0 1 2 3 0 1 2 3
- Reach a high shelf 0 1 2 3 0 1 2 3
- Lift 10 pounds above shoulder 0 1 2 3 0 1 2 3
- Throw a ball overhand 0 1 2 3 0 1 2 3
- Do usual work List: 0 1 2 3 0 1 2 3
- Do usual sport List: 0 1 2 3 0 1 2 3

## ACTIVITY

- Is your shoulder comfortable with your arm at rest by your side? Yes No
- Does your shoulder allow you to sleep comfortably? Yes No
- Can you reach the small of your back to tuck in our shirt with your hand? Yes No
- Can you place your hand behind your head with the elbow straight out to the side? Yes No
- Can you place a coin on a shelf at the level of your shoulder without bending your elbow? Yes No
- Can you lift 1 pound (a full pint container) to the level of our shoulder without bending your elbow? Yes No
- Can you lift 8 pounds (a full gallon container) to the level of the top of our head without bending your elbow? Yes No
- Can you carry 20 pounds (a bag of potatoes) at your side with the affected extremity? Yes No
- Do you think you can toss a softball underhand 10 yards with the affected extremity? Yes No
- Do you think you can throw a softball overhead 20 yards with the affected extremity? Yes No
- Can you wash the back of your opposite shoulder with the affected extremity? Yes No
- Would your shoulder allow you to work full-time at your regular job? Yes No
- On a scale of 0 to 100 with 100 being normal, how would you rate your shoulder on an average day over the last 2 weeks?

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## HISTORY

a. Do you remember a specific episode of trauma? If yes, when and please describe.

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If no, do you remember when you began to feel the discomfort? How long?

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Has it progressively gotten worse?

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b. Have you had a injury to this shoulder previously, If yes, when and please describe.

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Did you completely recover from this injury?

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c. Have you ever had an injury to your neck? Have you had any pain radiate down your arm to your forearm or hand No\_\_\_\_\_ If yes, when and please describe

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d. Do you have any grinding or crepitis in your shoulder? No\_\_\_\_ If yes, where

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e. Have you experienced any giving out or dislocation of your shoulder joint? No-

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If yes, please

describe\_\_\_\_\_

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f. Do you have any stiffness? No\_\_\_\_\_ Yes\_\_\_\_\_

When\_\_\_\_\_

g. What activities cause you to have pain in your shoulder?

Describe\_\_\_\_\_

Can you put your finger on the point that gives you the most pain?

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h. At the time of your injury, describe the pain.

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Dull, diffuse, burning throbbing, aching, sharp, knife-like?

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i. Has the pain changed? Yes or no? \_\_\_\_\_ How?\_\_\_\_\_

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Time span

0 \_\_\_\_\_ 5 \_\_\_\_\_ 10

Rate it on a scale of 1 to 10 (with 0 being none and 10 being excruciating)

j. What have you done since the injury?

\_\_\_\_\_

k. What makes the pain worse/what makes it better?

\_\_\_\_\_

l. Does pain wake you up at night?

\_\_\_\_\_

m. Have you had a blow to your stomach.

\_\_\_\_\_

### **OBSERVATION**

a. Condition of athlete: (Excellent - Good - Fair - Poor)

\_\_\_\_\_

b. Observe weight-description:

\_\_\_\_\_

c. Observe posture: description:

\_\_\_\_\_

d. Gross deformity description:

\_\_\_\_\_

e. Swelling: (Hemarthrosis - moderate - mild effusion)

\_\_\_\_\_

f. Discoloration: Echinosis and location.-description:

\_\_\_\_\_

### **PALPATION**

#### **RULE OUT A FRACTURE**

**(POSITIVE - NEGATIVE)**

**COMPRESSION**\_\_\_\_\_

**PERCUSSION**\_\_\_\_\_

**DISTRACTION**\_\_\_\_\_

|                                   | <b>Tender</b> | <b>Crepitus</b> |
|-----------------------------------|---------------|-----------------|
| 1. Spine of the scapula- T3 level | Yes/No        | Yes/No          |
| 4. Acromion process               | Yes/No        | Yes/No          |
| 7. Coracoid process               | Yes/No        | Yes/No          |
| 10..Inferior angle of the scapula | Yes/No        | Yes/No          |
| 13. Superior angle of the scapula | Yes/No        | Yes/No          |
| 16. Medial border of the scapula  | Yes/No        | Yes/No          |
| 19. Lateral border of the scapula | Yes/No        | Yes/No          |
| 22. Sternal end of the clavicle   | Yes/No        | Yes/No          |
| 25. Length of the clavicle        | Yes/No        | Yes/No          |
| 28. Lateral end of the clavicle   | Yes/No        | Yes/No          |
| 31. Sternoclavicular joint        | Yes/No        | Yes/No          |
| 34. Acromioclavicular joint       | Yes/No        | Yes/No          |
| 37. Bicipital groove              | Yes/No        | Yes/No          |
| 40. Humeral head                  | Yes/No        | Yes/No          |
| 43. Greater tubercle              | Yes/No        | Yes/No          |
| 46. Lesser tubercle               | Yes/No        | Yes/No          |
| 2. Deltoid tuberosity             | Yes/No        | Yes/No          |
| 5. Sternoclavicular lig           | Yes/No        | Yes/No          |
| 8. Costoclavicular lig            | Yes/No        | Yes/No          |
| 11. Coracoclavicular lig          | Yes/No        | Yes/No          |
| 14. cromioclavicular lig          | Yes/No        | Yes/No          |
| 17. Glenohumeral lig capsule      | Yes/No        | Yes/No          |
| 20. TrapeziusUpper fibers         | Yes/No        | Yes/No          |
| 23. Trapeziusmiddle fibers        | Yes/No        | Yes/No          |
| 26. Trapezius lower fibers        | Yes/No        | Yes/No          |
| 29. Deltoid anterior head         | Yes/No        | Yes/No          |
| 32. Deltoid middle head           | Yes/No        | Yes/No          |
| 35. Deltoid posterior head        | Yes/No        | Yes/No          |
| 38. Infraspinatus muscle belly    | Yes/No        | Yes/No          |
| 41. Greater tubercle humeral head | Yes/No        | Yes/No          |
| 44.. Supraspinatus muscle belly   | Yes/No        | Yes/No          |
| 47.Greater tubercle humeral head  | Yes/No        | Yes/No          |
| 3. Subscapularis muscle belly     | Yes/No        | Yes/No          |
| 6. Lesser tubercle of humerus     | Yes/No        | Yes/No          |

|                                    |        |        |
|------------------------------------|--------|--------|
| 9. Teres minor muscle belly        | Yes/No | Yes/No |
| 12. Geater tuberosity              | Yes/No | Yes/No |
| 15. Teres major muscle belly       | Yes/No | Yes/No |
| 18. Crest of the lesser tubercle   | Yes/No | Yes/No |
| 21 Latissimus dorsi muscle belly   | Yes/No | Yes/No |
| 24 Intertubercular groove          | Yes/No | Yes/No |
| 27. Serratus anterior muscle belly | Yes/No | Yes/No |
| 30. Pectoralis major               | Yes/No | Yes/No |
| 33. PM Clavicular portion          | Yes/No | Yes/No |
| 36. PM Sternal portion             | Yes/No | Yes/No |
| 39. Biceps brachii                 | Yes/No | Yes/No |
| 42. BB Long head                   | Yes/No | Yes/No |
| 45. BB Short head                  | Yes/No | Yes/No |
| 48. Tuberosity of the radius       | Yes/No | Yes/No |

## ASSESSING MOTION

### General ROM/ Goniometer /End Feel/ Muscle Testing w/Gravity/ w/out Gravity

Scapular Adduction \_\_\_\_\_

Scapular Abduction \_\_\_\_\_

Scapular Elevation \_\_\_\_\_

Scapular Depression \_\_\_\_\_

Flexion (0-180) \_\_\_\_\_

Extension (0-60) \_\_\_\_\_

Abduction (0-180) \_\_\_\_\_

Adduction \_\_\_\_\_

Horizontal Abduction (0-45) \_\_\_\_\_

Horizontal Adduction (0-135) \_\_\_\_\_

Internal Rotation (0-70) \_\_\_\_\_

External Rotation (0-90) \_\_\_\_\_

## RATINGS

General ROM (Painful-Limited-Full)

Goniometer (Percentage of Angle)

End Feel Normal (Bony - Soft Tissue Apposition - Soft Tissue Stretch - Capsular Stretch)

Abnormal (Hard - Soft- - Firm - Springy Block - Empty - Spasm)

Muscle Testing W/Gravity ( 5 4 4- 3+ 3 3- 2+ )

Muscle Testing W/out Gravity ( 2 2- 1+ 1 0 )

## STRESS TESTS

(+1 +2 +3)

Empty Can Test L\_\_\_\_\_ R\_\_\_\_\_ Yergason Test L\_\_\_\_\_ R\_\_\_\_\_ Speed's Test L\_\_\_\_\_ R\_\_\_\_\_

Drop Arm Test L\_\_\_\_\_ R\_\_\_\_\_ Apply's Scratch Test L\_\_\_\_\_ R\_\_\_\_\_

Cross-Over Impingement Test L\_\_\_\_\_ R\_\_\_\_\_

Neer Impingement Test L\_\_\_\_\_ R\_\_\_\_\_ Hawkins-Kennedy Imp. Test L\_\_\_\_\_ R\_\_\_\_\_

Sternoclavicular Joint Stress Test L\_\_\_\_\_ R\_\_\_\_\_

AC Joint Distraction Test L\_\_\_\_\_ R\_\_\_\_\_ Piano Key Sign L\_\_\_\_\_ R\_\_\_\_\_

Apprehension Test (Anterior) L\_\_\_\_\_ R\_\_\_\_\_

Sulcus Sign Test L\_\_\_\_\_ R\_\_\_\_\_ Anterior Drawer Test L\_\_\_\_\_ R\_\_\_\_\_

Apprehension Test (Posterior) L\_\_\_\_\_ R\_\_\_\_\_

Jobe Relocation Test L\_\_\_\_\_ R\_\_\_\_\_ Posterior Drawer Test L\_\_\_\_\_ R\_\_\_\_\_

Grind Test L\_\_\_\_\_ R\_\_\_\_\_

Clunk Test L\_\_\_\_\_ R\_\_\_\_\_ O'Brien Test L\_\_\_\_\_ R\_\_\_\_\_ Brachial Plexus Stretch Test L\_\_\_\_\_ R\_\_\_\_\_

Adson Maneuver L\_\_\_\_\_ R\_\_\_\_\_ Allen Test L\_\_\_\_\_ R\_\_\_\_\_ ROO Test L\_\_\_\_\_ R\_\_\_\_\_



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## NEUROLOGICAL EXAM

(POSITIVE - NEGATIVE)

NERVE ROOT LEVEL    SENSORY TESTING    MOTOR TESTING    REFLEX TESTING

C5 \_\_\_\_\_

C6 \_\_\_\_\_

C7 \_\_\_\_\_

C8 \_\_\_\_\_

T1 \_\_\_\_\_

## CIRCULATORY EXAM (POSITIVE - NEGATIVE)

Brachial Pulse \_\_\_\_\_ Radial Pulse \_\_\_\_\_

## FUNCTIONAL TESTS

ACTIVITY SPECIFIC

1.

2.

3.

4.

5.

## NOTES

Impression: \_\_\_\_\_

Referral: Emergency

Acute Management: Crutches \_\_\_\_\_ Posterior Splint \_\_\_\_\_ Compression Bandage \_\_\_\_\_ Air Caist \_\_\_\_\_

Diagnostic Tests:

X-rays: Anterior-Posterior & Lateral view

\_\_\_\_\_

Ultrasound \_\_\_\_\_

\_\_\_\_\_

MRI \_\_\_\_\_

\_\_\_\_\_