ELBOW ASSESSMENT SHEET

AFFIX PATIENT LABEL HERE

Date: _____

Are you Left / Right handed? _____

Elbow Affected Left / Right

How long has your elbow been bothering you? _____

Did you injure your elbow? Yes / No Date of injury? _____

Please give a brief description of your elbow problem and any injuries that may have occurred _____

_____

_____

_____

What treatment have you had to date? _____

_____

What activities does you elbow limit you from doing? _____

_____

_____

ELBOW SCORE: Please circle ALL responses that apply to you.

I AM EASILY ABLE TO

Comb/brush my hair

Feed myself

Perform personal hygiene tasks

Do up top button on my shirt

Put on up my shoes

Please circle the response that BEST applies to you.

THE PAIN I GET FROM MY ELBOW AT ITS WORST IS

None

Mild

Moderate

Severe

CLINICAL EXAMINATION

INDEX SIDE	[ ] LEFT	[ ] RIGHT	
ALIGNMENT	[ ] NORMAL	[ ] CUBITUS VALGUS	[ ] CUBITUS VARUS
MUSCLE WASTING	[ ] HYPOTHENAR	[ ] THENAR	[ ]FOREARM [ ] NIL
EFFUSION	[ ] NO	[ ] YES	
TENDERNESS	[ ] RAIOCAPITELLAR	[ ] ULNOHUMERAL	[ ] TRICEPS
	[ ] MEDIAL FLEXOR ORIGIN	[ ] LATERAL EXTENSOR ORIGIN	[ ] UNLAR NERVE
EXTENSION	[ ] FULL	[ ] FFD	[ ] LAG
FLEXION	[ ] FULL	[ ] LIMITED	
FLEXION-EXTENSION ARC	[ ] >100Ä	[ ] 50Ä-100Ä	[ ] < 50Ä
SUPINATION	[ ] FULL	[ ] LIMITED	
PRONATION	[ ] FULL	[ ] LIMITED	
SUPINATION – PRONATION ARC	[ ] >100Ä	[ ] 50Ä-100Ä	[ ] < 50Ä
VARUS-VALGUS STABILITY	[ ] STABLE	[ ] <10ÄLAXITY	[ ] >10ÄLAXITY
PLRI	[ ] PLR DRAW	[ ] LATERAL PIVOT SHIFT	
CAPITELLAR SHEAR TEST(MVST AT 45Ä	[ ] NO	[ ] YES	
PLICA IMPINGEMENT TEST	[ ] ANTERIOR (FLEX AND PRON)	[ ] POSTERIOR (EXT AND SUP)	[ ] NIL
TENNIS ELBOW SHEAR TEST	[ ] NO	[ ] YES	
GOLFERS ELBOW SHEAR TEST	[ ] NO	[ ] YES	
MOVING VALGUS STRESS TEST	[ ] NO	[ ] YES	
ULNA NERVE TINNELS	[ ] NO	[ ] YES	
SUBLUXING ULNAR NERVE	[ ] NO	[ ] YES	
BICEPS HOOK TEST	[ ] NO	[ ] YES	
IMPINGEMENT	[ ] IN FLEXION	[ ] IN EXTENSION	[ ] NIL
ULNOHUMERAL JOINT LOADING	[ ] NORMAL	[ ] CREPITUS	[ ] PAIN
RADIOCAPITELLAR JOINT LOADING	[ ] NORMAL	[ ] CREPITUS	[ ] PAIN
NECK	[ ] PAINFREE FULL ROM	[ ] LIMITED ROM OR PAIN	

XRAY _____

MRI /US_____

PROVISIONAL DIAGNOSIS _____

MANAGEMENT PLAN _____