SHOULDER ASSESSMENT SHEET

AFFIX PATIENT LABEL HERE

Date:		1	ı
Are you Left / Right hand	ded?	_	_
Shoulder Affected	Left / Right		
How long has your shou	lder been bothering you?	?	
Did you injure your shou	lder? Yes / No	Date of injury?	
-		problem and any injuries that may have occurre	
What activities does you	shoulder limit you from	doing?	
SHOULDER SCORE: P	lease <u>circle</u> all responses	s that apply to you in each section.	
MY SHOULDER LIMITS	MY SHOULDER HURTS	WHEN I MY SHOULDER FEELS LIKE IT IN DISLOCATE	<u>MAY</u>
My work	Above my head	Every time I use it	
My recreation / sport	Behind my waist	At least once a week	
My sleep	Sideways	At least once a month	
	Forwards	At least once a year	
Please <u>circle</u> the single ı	most appropriate respons	se in each section	

PAIN AT ITS WORST	HIGHEST LEVEL YOU CAN REACH	ACTIVITY LEVEL
No pain	Waist height	Unable to use arm at all
Mild	Chest height	Only light activities possible
Moderate	Neck height	Able to do most daily activities
Severe	Head height	Can work above shoulder height but restricted

Above head Can do normal activities

CLINICAL EXAMINATION

MUSCLE WASTING	[] DELTOID	[]	SUPRASPIN	[]INFRASPIN		[] NIL	[]NIL		
PSEUDOSWELLING	[]YES	1[]	NO						
TENDERNESS	[]ACJ	[](GT	[]BICE	PS	[]PO	ST GHJ		
FORWARD ELEVATION	N EXTERNAL	ROTATIO	<u>ration</u>		INTERNAL ROTATION				
[] 0 – 30		[] HAND BEHIND HEAD, ELBOW FORWARD			[] HAND TO LATERAL THIGH				
[] 31 – 60	[]HANDE	[] HAND BEHIND HEAD, ELBOW BACK			[] HAND TO BUTTOCK				
[] 61 – 90		[] HAND ON TOP OF HEAD, ELBOW FORWARD				[] HAND TO LS JUNCTION			
[] 91 – 120	[]HAND ([] HAND ON TOP OF HEAD, ELBOW BACK			[] HAND TO WAIST (L3)				
[] 121 – 150	[]FULLEI	[] FULL ELEVATION FROM TOP OF HEAD			[] HAND TO T12				
[] 151 – 180					[]HAND	TO SCAP	ULA (T7)		
Power in abduction at 90	0° (Max 25 pou	nds)							
Forward elevation streng	gth (Supraspina	atus) C	1 2 3 4 5	Affe	ected by pa	ain []YE	S []NO		
External rotation arm by side (Infraspinatus) 0 1 2 3 4 5 Affected by pain [] YES [] NO									
HORNBLOWERS SIGN	(TERRES MIN	IOR)	[]YES		[] NO				
BELLY PRESS TEST	[]YES	[] NO	LIFT OFF TEST	Γ	[]YES	[] NO			
HAWKINS IMPINGEMENT	[]YES	[]NO	NEERS IMPINGEMENT	Г	[]YES	[]NO			
O'BRIEN'S TEST	[]YES	[] NO	LABRAL SHEA	R TEST	[]ANT	[] POST	[]NIL		
YERGESON'S TEST	[]YES	[] NO	SPEED'S TEST	Γ	[]YES	[] NO			
JERK TEST	[]YES	[] NO							
JOBES APPREHENSIC TEST	N / RELOCATI	ON	[]YES		[] NO				
SULCUS SIGN	[]YES	[] NO	LIG LAX		[]YES	[] NO			
LOAD AND SHIFT TEST	Т	1 2	2 3 P	OSTERIO	R	1	2 3		
NECK	[]PAINFREE	FULL RO] N] LIMITED	ROM OR	PAIN			
XRAY									
MRI/US									
PROVISIONAL DIAGNOSIS									
MANAGEMENT PLAN									