Shoulder Evaluation

Name:_____**Sport:**_____ **Date:**_____
BP:_____ **HR:**_____ **Practice**_____ **Game**_____ **Evaluator:**_____

HISTORY

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

_____

If no, do you remember when you began to feel the discomfort? How long?_____
Has it progressively gotten worse? _____

b. Have you had a injury to this shoulder previously, If yes , when and please describe._____
Did you complety recover from this injury? _____

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_____

d. Do you have any grinding or crepitis in your shoulder. No___ If yes, where _____

e. Have you exprienced any giving out or dislocation of your shoulder joint. No-_____
If yes, please describe_____

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?_____

h. At the time of your injury, describe the pain._____
Dull, diffuse, burning throbbing, aching, sharp, knife-like?_____

i. Has the pain changed? Yes or no?____ How?_____ _____
Time span_____
Rate it on a scale of 1 to 10 (with 0 being none and 10 being excrutiating)

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:Echymosis and location.-description:_____

PALPATION

RULE OUT A FRACTURE
(POSITIVE - NEGATIVE) COMPRESSION_____ **PERCUSSION**_____ **DISTRACTION**_____

	Tender	Crepitus		Tender	Crepitus		Tender	Crepitus
1. Spine of the scapula- T3 level	Yes/No	Yes/No	**2.** Deltoid tuberosity	Yes/No	Yes/No	**3.** Subscapularis muscle belly	Yes/No	Yes/No
4. Acriomion process	Yes/No	Yes/No	**5.** Sternoclavicular lig	Yes/No	Yes/No	**6.** Lesser tubercle of humerus	Yes/No	Yes/No
7. Coracoid process	Yes/No	Yes/No	**8.** Costoclavicular lig	Yes/No	Yes/No	**9.** Teres minor muscle belly	Yes/No	Yes/No
10..Inferior angle of the scapula	Yes/No	Yes/No	**11.** Coracoclavicular lig	Yes/No	Yes/No	**12.** Geater tuberosity	Yes/No	Yes/No
13. Superior angle of the scapula	Yes/No	Yes/No	**14.** cromioclavicular lig	Yes/No	Yes/No	**15.** Teres major muscle belly	Yes/No	Yes/No
16. Medial border of the scapula	Yes/No	Yes/No	**17.** Glenohumeral lig capsule	Yes/No	Yes/No	**18.** Crest of the lesser tubercle	Yes/No	Yes/No
19. Lateral border of the scapula	Yes/No	Yes/No	**20.** TrapeziusUpper fibers	Yes/No	Yes/No	**21** Latissimus dorsi muscle belly	Yes/No	Yes/No
22. Sternal end of the clavicle	Yes/No	Yes/No	**23.** Trapeziusmiddle fibers	Yes/No	Yes/No	**24** Intertubercular groove	Yes/No	Yes/No
25. Length of the clavicle	Yes/No	Yes/No	**26.** Trapezius lower fibers	Yes/No	Yes/No	**27.** Serratus anterior muscle belly	Yes/No	Yes/No
28. Lateral end of the clavicle	Yes/No	Yes/No	**29.** Deltoid anterior head	Yes/No	Yes/No	**3 0.** Pectoralis major	Yes/No	Yes/No
31. Sternoclavicular joint	Yes/No	Yes/No	**32.** Deltoid middle head	Yes/No	Yes/No	**33.**PM Clavicular portion	Yes/No	Yes/No
34. Acromioclavicular joint	Yes/No	Yes/No	**35.** Deltoid posterior head	Yes/No	Yes/No	**36.** PM Sternal portion	Yes/No	Yes/No
37. Bicipital groove	Yes/No	Yes/No	**38.** Infraspinatus muscle belly	Yes/No	Yes/No	**39.** Biceps brachii	Yes/No	Yes/No
40. Humeral head	Yes/No	Yes/No	**41.** Greater tubercle humeral head	Yes/No	Yes/No	**42.** BB Long head	Yes/No	Yes/No
43. Greater tubercle	Yes/No	Yes/No	**44.**. Supraspinatus muscle belly	Yes/No	Yes/No	**45.** BB Short head	Yes/No	Yes/No
46. Lesser tubercle	Yes/No	Yes/No	**47.**Greater tubercle humeral 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	Muscle Testing 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	(Painfull-Limited-Full)
Goniometer	(Prcentage 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 Impengement 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_____

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 Room_____

Physician's Office_____

Acute Management: Crutches____ Posterior Splint____ Compression Bandage____ Air Caist ____ Vacuum Splint____ Speedi Splint____

Diagnostic Tests:

X-rays: Anterior/Posterior view_____

Lateral view_____

Mortis view_____

Anterior/Posterior view with stress_____

Bone Scan:_____