

Date: _____

Patient name: _____ Claim no: _____

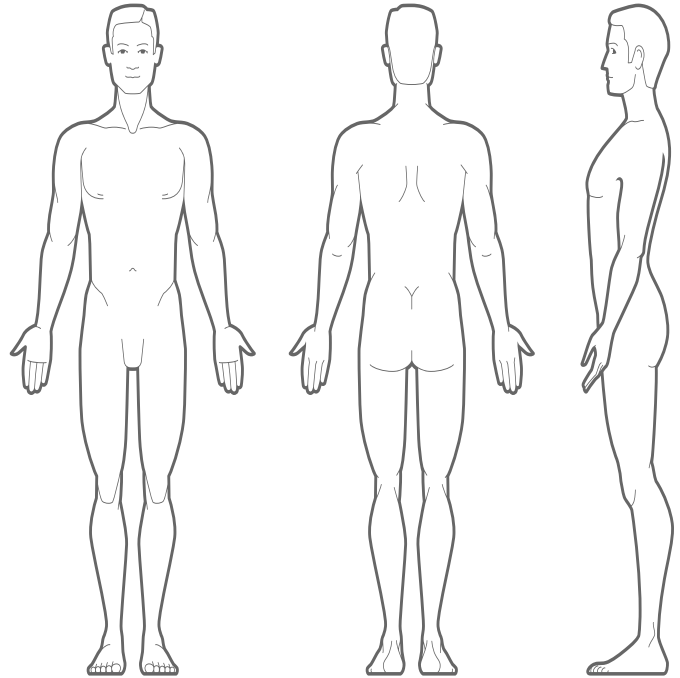
Functional examination record

Upper quadrant assessment

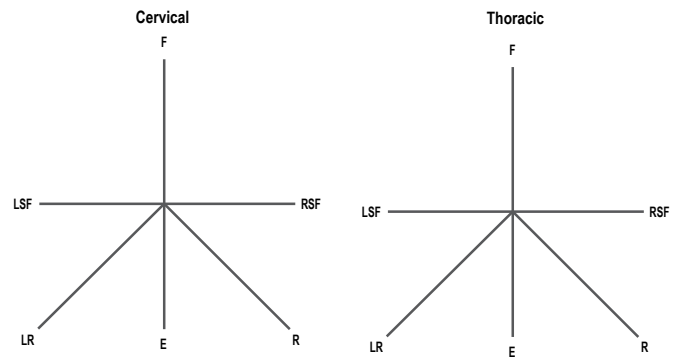
Posture/Dermatomes

Pain/Light touch

Upper extremities		ROM		Strength	
		R	L	R	L
Shoulder girdle	Elev				
	Depr				
	Prot				
	Retr				
Shoulder	Flex				
	Ext				
	Abd				
	Add				
	FER				
	FIR				
Elbow	Flex				
	Ext				
	Supin				
	Pron				
Wrist	Flex				
	Ext				
	RDev				
	UDev				



ROM



Resisted movements (↓ pain)

Flex	R.Sb	R.Rot
Ext	L.Sb	L.Rot

Comments



<u>Reflexes</u>	Right	Left	Normal
C4 LS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C5 PD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C6 Bi	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C7 Tri	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C8 EPL	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
T1 Abd dig min	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Babinski	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hoffman's	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Clonus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<u>Myotomes</u>	Right	Left	Normal
C3-4 UT (Sh Shrug)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C5 Del	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C5-6 Bi	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C6-7 We	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C7 Tri	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C8 Thumb Ext	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
T1 Interossei	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Cranial nerve tests

		R	L	N
Olfactory	Smell	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Optic	Light reaction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Accommodation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Confrontation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Occulomotor	Fixation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Trochlear	Fixation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Trigeminal	Facial sensation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Jaw reflex	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Abducens	Fixation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Facial	Smile/frown	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vestibulocohear	Lie down/sit up	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Side tilt	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Caloric	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Finger rustle	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Humming	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Weber's	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rhine's	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Glossopharygeal/ Vagal	Gag reflex	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Accessory	Sternomastoid/ Trapezius strength	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Tongue protrusion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Tenderness to palpation

Extremity

Shoulder:

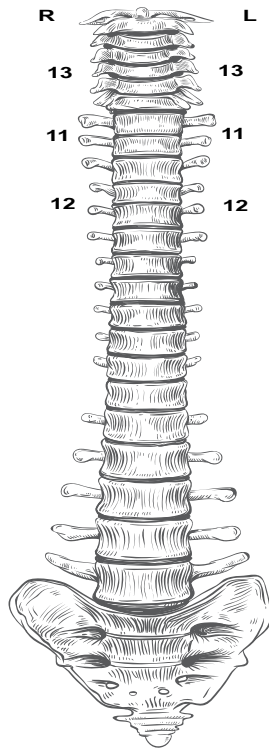
Wrist:

Elbow:

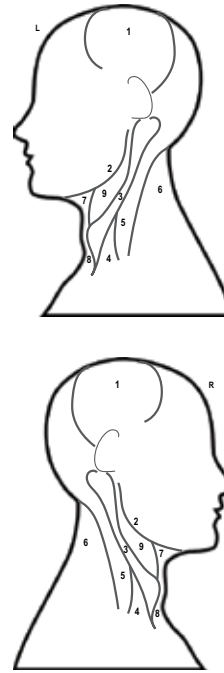
Hand:

Skeletal

- Tender
- Sore
- ✕ Stiff
- ★ Spasm
- / Hypermobile
- E** Extended
- F** Flexed



Soft tissue



- 1 - TM
- 2 - Mass
- 3 - SCM
- 4 - SC anterior
- 5 - SC medius
- 6 - SC posterior
- 7 - Suprahyoids
- 8 - IHM
- 9 - Prevertebral
- 10 - TR
- 11 - LS
- 12 - IS
- 13 - PV
- 14 - Subscapularis

Special tests

TMJ

Opening _____ mm
 Lat D (R) _____ mm
 (L) _____ mm

Oral habits

Tongue position Palate _____ Floor _____
 Between teeth _____
 Thrust _____

Breathing Mouth _____ Nose _____

Shoulder (+ve, -ve) **R** **L**
 Impingement sign
 Apprehension test
 Scapulohumeral rhythm

Acromioclavicular

Sternoclavicular

Elbow (+ve, -ve)

Valgus/Varus stress

Tennis elbow test

Cervical

		+ve	-ve
Ligament stability	Alar	<input type="checkbox"/>	<input type="checkbox"/>
	Transverse	<input type="checkbox"/>	<input type="checkbox"/>
Compression		<input type="checkbox"/>	<input type="checkbox"/>
Distraction		<input type="checkbox"/>	<input type="checkbox"/>
Upper limb Ten test		<input type="checkbox"/>	<input type="checkbox"/>
Neck flex		<input type="checkbox"/>	<input type="checkbox"/>
Scapular retraction test		<input type="checkbox"/>	<input type="checkbox"/>
Vertebral artery test (+ve, -ve)		R	L
Carotid pulse		<input type="checkbox"/>	<input type="checkbox"/>
Rotation		<input type="checkbox"/>	<input type="checkbox"/>
Rotation w/ ext		<input type="checkbox"/>	<input type="checkbox"/>
Body rotation		<input type="checkbox"/>	<input type="checkbox"/>
Hautaud's test		<input type="checkbox"/>	<input type="checkbox"/>
Pulses	Subclavicular	<input type="checkbox"/>	<input type="checkbox"/>
	Brachial	<input type="checkbox"/>	<input type="checkbox"/>
	Radial	<input type="checkbox"/>	<input type="checkbox"/>

Wrist (+ve, -ve)

Phalen's test

Allen's test

Biomechanical scan

Lumbar Positional tests

Neutral

Flexion

Extension

Hip Faber's

Thomas

Grind

Knee MCL

LCL

ACL

PCL

McMurray's

Appley's

 Compression

 Distraction

Ankle Medial ligament

Lateral ligament