**WALTER R. LOWE, M.D.**
**INITIAL SHOULDER EXAM**
**(THIS PAGE TO BE COMPLETED BY PATIENT)**

(Place UT Label Here)

Patient Name: ______________________ Date of Visit: ____ /____ /____

Referred by: ______________________ Date of Injury / Onset: ______________________

Current Medications: ______________________ Allergies: ______________________ ❒ **NONE**

Chief Complaint: ❑ Left ❑ Right Please Explain: ______________________

**PAST SHOULDER HISTORY**

Have you had any previous shoulder problems? ❒ Yes ❒ No If yes, which shoulder? ❒ Left ❒ Right ❒ Both

If YES, what was the injury? ______________________

Did any shoulder injury require surgery? ❒Yes ❒No If yes, which shoulder? ❒ Left ❒ Right ❒ Both

If YES, what procedure and when? ______________________

**PLEASE COMPLETE THE FOLLOWING QUESTIONS.**

**SYMPTOMS:** (Click on YES or NO to respond.)

❒ Yes ❒ No 1. Is your shoulder comfortable at your side?
❒ Yes ❒ No 2. Does your shoulder allow you to sleep comfortably?
❒ Yes ❒ No 3. Can you reach the small of your back to tuck in your shirt?
❒ Yes ❒ No 4. Can you place your hand behind your head with your elbow straight out to the side?
❒ Yes ❒ No 5. Can you place a coin on a shelf at shoulder level without bending your elbow?
❒ Yes ❒ No 6. Can you lift 1 lb. (a full pint container) to shoulder level without bending your elbow?
❒ Yes ❒ No 7. Can you lift 8 lbs. (a full gallon container) to shoulder level without bending your elbow?
❒ Yes ❒ No 8. Can you carry 20 lbs. at your side with the affected upper extremity?
❒ Yes ❒ No 9. Do you think you can toss a softball underhand 10 yards with the affected upper extremity?
❒ Yes ❒ No 10. Do you think you can toss a softball overhand 20 yards with the affected upper extremity?
❒ Yes ❒ No 11. Can you wash the back of your opposite shoulder with the affected upper extremity?
❒ Yes ❒ No 12. Would your shoulder allow you to work a full time job at your current regular job?

**ACTIVITY**: Do you have problems with the following?

❒ Yes ❒ No 1. Are you currently receiving physical therapy for the affected upper extremity?
If YES, where are you going for your physical therapy? ______________________
❒ Yes ❒ No 2. Do your symptoms allow you to play sports? Explain: ______________________
❒ Yes ❒ No 3. Are you currently working?
If YES, are you… ❒ Full Duty ❒ Light Duty Explain: ______________________

**FUNCTION:** (Click on the appropriate circle to respond.)

1. How would you rate your overall level of pain? None … ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ … Disabling
2. How would you rate your shoulder comfort with your arm at REST? None … ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ … Painful
3. How would you rate your shoulder comfort during SLEEP? None … ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ … Painful
4. How would you rate your overall level of shoulder function with the affected upper extremity? Comfortable … ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ … Unable to Use
5. How would you rate your ability to use your arm full time at work or for playing sports? No Problem … ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ … Unable to Use
6. How would you rate your overall quality of life as is with your shoulder injury? Very Good … ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ … Very Bad

**DO YOU PLAY SPORTS?** ❑ Yes ❑ No What Sport? ______________________ Position: ______________________

**WHAT LEVEL OF SPORT?** ❑ High School ❑ College ❑ Other ______________________

Where do you go to school? ______________________

**(THIS PAGE TO BE COMPLETED BY PATIENT)**

**WALTER R. LOWE, M.D.**
**INITIAL SHOULDER EXAM**
**(THIS PAGE TO BE COMPLETED BY PHYSICIAN)**

(Place UT Label Here)

Patient Name: ______________________ Date of Visit: ____ /____ /____

Chief Complaint: ❑ Left ❑ Right Please Explain: ______________________

**TENDERNESS:** ❑ AC Joint ❑ Anterior Acromion ❑ Posterior Acromion ❑ Coracoid ❑ Bicipital Groove ❑ ____________

**RANGE OF MOTION:**

| PATIENT SITTING | LEFT | RIGHT | PATIENT SUPINE | LEFT | RIGHT |
|---|---|---|---|---|---|
| | ❑ FULL | ❑ FULL | | ❑ FULL | ❑ FULL |
| Active Horizontal Abduction | _______ | _______ | Passive Horizontal Abduction | _______ | _______ |
| Active Forward Flexion | _______ | _______ | Passive External Rotation | _______ | _______ |
| Active Internal Rotation | _______ | _______ | | | |
| Active External Rotation | _______ | _______ | | | |
| Passive Internal Rotation | _______ | _______ | | | |
| Passive External Rotation | _______ | _______ | | | |
| Scapular Motion | ❑ Synchronous | | ❑ Asynchronous | | |

**MUSCLE STRENGTH:**

| | | | | | |
|---|---|---|---|---|---|
| Deltoid | _______ / 5 | ❑ Painful | Biceps | _______ / 5 | ❑ Painful |
| Scaption | _______ / 5 | ❑ Painful | Triceps | _______ / 5 | ❑ Painful |
| Lift-Off | _______ / 5 | ❑ Painful | Wrist Extension | _______ / 5 | ❑ Painful |
| External Rotation | _______ / 5 | ❑ Painful | Wrist Flexion | _______ / 5 | ❑ Painful |
| Internal Rotation | _______ / 5 | ❑ Painful | Finger Abduction | _______ / 5 | ❑ Painful |

**STABILITY:**

| | | | | |
|---|---|---|---|---|
| Anterior | ❑ NORMAL | ❑ Apprehension | ❑ Subluxation | Relocation: ❑ (+) ❑ (-) |
| Posteior | ❑ NORMAL | ❑ Apprehension | ❑ Subluxation | Relocation: ❑ (+) ❑ (-) |
| Inferior | ❑ NORMAL | ❑ Apprehension | ❑ Subluxation | Relocation: ❑ (+) ❑ (-) |

**IMPINGEMENT SIGNS:** ❑ NORMAL
❑ Neer ❑ Hawkins ❑ Jobe ❑ Speed ❑ O'Brien ❑ SLAP Test

**CERVIAL SPINE EXAM:** ❑ NORMAL EXAM

| | | |
|---|---|---|
| Range of Motion | ❑ Normal | ❑ Abnormal |
| Head Compression | ❑ Negative | ❑ Positive |
| Foraminal Closure | ❑ Negative | ❑ Positive |

| SENSORY | (N) | (↓'D) | SENSORY | (N) | (↓'D) |
|---|---|---|---|---|---|
| C -1 | ❑ | ❑ | C -6 | ❑ | ❑ |
| C -2 | ❑ | ❑ | C -7 | ❑ | ❑ |
| C -3 | ❑ | ❑ | C -8 | ❑ | ❑ |
| C -4 | ❑ | ❑ | T -1 | ❑ | ❑ |
| C -5 | ❑ | ❑ | | | |

**X-RAYS:** ❑ YES ❑ NO Site / Views: ______________________
Results: ______________________

**IMAGING:** ❑ Brought in MRI to Exam Results: ______________________
❑ Order MRI Location: ____________ Reason: ______________________
MRI Type: ❑ MRI with IA GAD ❑ MRI w/o IA GAD Other: ______________________

**IMPRESSION:** ______________________

______________________

**PLAN:** ❑ Aspiration Amount: ________ Description: ______________________
❑ Injection Medication(s): ______________ Location: ______________
❑ PHYSICAL THERAPY

| | | |
|---|---|---|
| ❑ RC Strengthening | ❑ Anterior Instability | ❑ Arthroscopic Bankart |
| ❑ SS Strengthening | ❑ Posterior Instability | ❑ Open Bankart |
| ❑ Rotator Cuff Repair | ❑ SLAP Repair | ❑ ____________ |

❑ If no changes in improvement, order an MRI to rule out: ______________________
❑ Patient to call to report progress (Explain): ______________________

**SURGICAL PROCEDURE:** ______________________

______________________

**COMMENTS:** ______________________

______________________

**TIME SPENT WITH PATIENT:** ____________
❑ Over 50% of time spent with patient was for counseling regarding: ______________________

**RETURN TO CLINIC:** _______ weeks / months
**RETURN TO WORK:** ❑ No Work ❑ Light Duty ❑ Full Duty

______________________
*Fellow / Resident Signature*

❑ I agree with the exam and plan of care for this patient.
❑ I agree with the exam and plan of care for this patient, except for the following modifications:

______________________

**(THIS PAGE TO BE COMPLETED BY PHYSICIAN)**

______________________
*Physician / Physician Assistant Signature*