



THERAPRACTICS SHOULDER RE-EVAL

PATIENT: _____ DATE: _____

PATIENT #: _____ EMPLOYER: _____

DIAGNOSIS: _____ PHYSICIAN: _____

GENERAL COMMENTS

Pain level & % improvement: _____

Since the Initial Eval. on _____ / Re-Eval. on _____ the patient has had _____ treatments.

The patient's physical therapy treatment program has consisted of: Ther. Exs. STM Jt. Mobs. IFC

U.S. Iontophoresis Other: _____

The patient has had a total of _____ treatments since the Initial Evaluation.

ASSESSMENT / OBJECTIVE PALPATION: _____

RANGE OF MOTION	LEFT		RIGHT	
	ACTIVE	PASSIVE	ACTIVE	PASSIVE
Flexion 0° - 180°	/	/	/	/
Extension 0° - 40°	/	/	/	/
Abduction 0° - 180°	/	/	/	/
Int. Rotation 0° - 90°	/	/	/	/
Ext. Rotation 0° - 90°	/	/	/	/

STRENGTH:	LEFT		RIGHT		
	LEFT	RIGHT	LEFT	RIGHT	
Shld. Flexion	/5	/5	Shld. Extension	/5	/5
Shld. Abduction	/5	/5	Shld. Adduction	/5	/5
Shld. Int. Rotation	/5	/5	Shld. Ext. Rotation	/5	/5
Shld. Horiz. Abd.	/5	/5	Shld Horiz. Add.	/5	/5

SUMMARY: The patient has made Good Fair Poor progress in physical therapy.

Additional comments: _____

Recommend that the patient be Discharged to a H.E.P. Continue with the following treatment plan:

Treatment Plan: Ther. Exs. STM Jt. Mobs. IFC U.S. Iontophoresis Other: _____

Frequency: _____ x/wk. Duration: _____ wks.

R.P.T., D.C.