Labral Tear Test

Patient Information

Patient Name: _____

Age: _____

Gender: _____

Medical Record Number: _____

Medical History

Relevant Medical History:

Previous Shoulder Injuries/Surgeries:

Current Medications:

Allergies:

Symptoms Assessment

Duration of Symptoms: _____

Pain Description:

- Scale (1-10): _____
- Location: _____
- Triggering Activities: _____

Range of Motion Limitations:

Functional Limitations:

Other Symptoms:

Physical Examination

Visual Inspection:

Palpation:

Range of Motion Testing:

Special Tests for Labral Tear:

O'Brien's Test: _____

Biceps Load Test II: _____

Anterior Slide Test: _____

Other Tests: _____

Findings:

Imaging and Diagnostic Tests

X-Ray:

Findings:

MRI:

Findings:

Arthroscopy (if applicable):

Findings:

Other Tests: _____

Findings:

Diagnosis

Preliminary Diagnosis: _____

Type of Labral Tear (if confirmed): _____

Severity: _____

Treatment Plan

Conservative Management:

Physical Therapy:

Medications:

Activity Modifications:

Surgical Options:

Recommended Procedure:

Expected Outcomes:

Follow-Up Schedule: _____

Clinician's Notes and Observations

Patient Education and Guidance

Information Provided:

Patient's Understanding and Questions:

Clinician's Signature: _____

Date: _____