

# Shoulder Exam Checklist

Patient information	
Name	Age
Date of birth	Phone number
<b>Please check all assessments done and provide findings in the designated fields</b>	
<input type="checkbox"/> <b>Subjective assessment</b>	
Chief complaint	
History of present illness	
Past medical history	
Previous shoulder injuries or surgeries	
Medications	
Allergies	

**Objective assessment**

Inspection

Palpation

Range of motion (ROM)

Strength testing

Special tests

**Neurovascular assessment**

**Functional assessment**

**Summary of findings**

**Recommendation****Additional notes**