Shoulder Exam Checklist

Patient information	
Name	Age
Date of birth	Phone number
Please check all assessments done and provide findings in the designated fields	
☐ **Subjective assessment**	
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