

Shoulder Relocation Test

Section	Details
Patient Information	
Full Name	
Age	
Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Prefer not to say <input type="checkbox"/> Other: _____
Date of Assessment	
Contact Number	
Medical History	
Known Shoulder Issues	
Previous Injuries	
Previous Surgeries	
Medications	
Allergies	
Questions	
Onset of Pain/Discomfort	
Aggravating Activities	
Relieving Activities	
Tests	
Apprehension Test	<input type="checkbox"/> Positive <input type="checkbox"/> Negative
Relocation Procedure	<input type="checkbox"/> Positive <input type="checkbox"/> Negative

Sulcus Sign	<input type="checkbox"/> Positive <input type="checkbox"/> Negative
Load and Shift Test	<input type="checkbox"/> Positive <input type="checkbox"/> Negative
Speed's Test	<input type="checkbox"/> Positive <input type="checkbox"/> Negative
O'Brien's Test	<input type="checkbox"/> Positive <input type="checkbox"/> Negative
Drop Arm Test	<input type="checkbox"/> Positive <input type="checkbox"/> Negative
Findings	
Observable Displacement	
Range of Motion	
Muscle Strength	
Joint Sound (Crepitus)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Swelling	<input type="checkbox"/> Yes <input type="checkbox"/> No
Interpretation	
Individual Test Results	
Overall Interpretation	