



Acupuncture-Chiropractic-Massage Network - Pain Management Center, Inc.
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SHOULDER RE-EXAM as of ____ **Chiropractic** ____ **Acupuncture** ____ **Massage VISITS**

PATIENT:
Claim #:
Chart #:

Re-Exam Date (Now):
Initial Exam Date (Prior):
PTP:

INJURED SIDE: ☐ **RIGHT** ☐ **LEFT**

SHOULDER	PRIOR	CURRENT
Location		
% of Time	☐ 25% ☐ 50% ☐ 75% ☐ 90-100%	☐ 25% ☐ 50% ☐ 75% ☐ 90-100%
Numerical Scale	/10	/10
Functional Scale*	/80	/80 (80/80 = Full Function)
Medication		
Medication	☐ n/a: none	
Orthoses	☐ n/a: none	
+ Ortho/Neuro		
+ Ortho/Neuro		
Mood Complaint	☐ n/a: none	

*Functional Scale Attached

SHOULDER	R/L/NORM Prior	ROM PAIN Prior	R/L/NORM Now	ROM PAIN Now
Flexion	/180°	☐ R ☐ L	/180°	☐ R ☐ L
Extension	/50°	☐ R ☐ L	/50°	☐ R ☐ L
Abduction	/180°	☐ R ☐ L	/180°	☐ R ☐ L
Adduction	/50°	☐ R ☐ L	/50°	☐ R ☐ L
Ext. Rotation	/90°	☐ R ☐ L	/90°	☐ R ☐ L
Int. Rotation	/90°	☐ R ☐ L	/90°	☐ R ☐ L

- ☐ **Improvement from the current course of care was demonstrated by the following**
- ☐ Decreased area of pain ☐ Decreased radiation of pain ☐ Decreased frequency of pain
 - ☐ Improved ability to perform ADL ☐ Decreased numerical rating of pain
 - ☐ Decreased use of medication ☐ n/a: not used when first seen or now
 - ☐ Decreased use of orthoses ☐ n/a: not used when first seen or now
 - ☐ Decreased positive ortho/neuro tests
 - ☐ Increased ROM ☐ Decreased ROM pain
 - ☐ Successful participation in a progressive conditioning program/decreased passive coping
 - ☐ Improved Mood ☐ n/a: no complaints when first seen or now

Patient:
Re-Exam Last Visit of Course:

2

- ☐ **Further improvement is anticipated from a new course of care REQUESTED to include**
Manual ☐ Manipulation ☐ Myofascial Release ☐ Mobilization ☐ Massage ☐ Massage 4 units
Exercise ☐ Strengthening ☐ Flexibility ☐ Cardio ☐ Proprioception ☐ Body Mechanics
Modalities ☐ Electrical: _____ ☐ Thermal: _____
☐ Instrument Assisted Soft Tissue Therapy
☐ Acupuncture/Electroacupuncture
☐ Pain Education ☐ Lifestyle Advice ☐ Other: _____
- ☐ **No improvement from current course of care and not anticipated from additional course**
- ☐ **Maximum Medical Benefit has been achieved from the current course of care**
- ☐ **Patient reports full recovery after completion of the current course of care**

Provider Name

Provider Signature

Upper Extremity Functional Scale

Please indicate whether you are having any difficulty with activities because of your lower limb problems by marking **one** answer for each activity listed below.

Activities	Extreme Difficulty Or Unable to Perform Activity	Quite a Bit of Difficulty	Moderate Difficulty	A Little Bit of Difficulty	No Difficulty
Any of your usual work, household, or school activities	☐	☐	☐	☐	☐
Your usual hobbies, recreational or sporting activities	☐	☐	☐	☐	☐
Lifting a bag of groceries to waist level	☐	☐	☐	☐	☐
Lifting a bag of groceries above your head	☐	☐	☐	☐	☐
Grooming your hair	☐	☐	☐	☐	☐
Pushing up on your hands (e.g., from bathtub or chair)	☐	☐	☐	☐	☐
Preparing food (peeling, cutting)	☐	☐	☐	☐	☐
Driving	☐	☐	☐	☐	☐
Vacuuming, sweeping, or raking	☐	☐	☐	☐	☐
Dressing	☐	☐	☐	☐	☐
Doing up buttons	☐	☐	☐	☐	☐
Using tools or appliances	☐	☐	☐	☐	☐
Opening doors	☐	☐	☐	☐	☐
Cleaning	☐	☐	☐	☐	☐
Tying or lacing shoes	☐	☐	☐	☐	☐
Sleeping	☐	☐	☐	☐	☐
Laundering clothes (e.g., washing, ironing, folding)	☐	☐	☐	☐	☐
Opening a jar	☐	☐	☐	☐	☐
Throwing a ball	☐	☐	☐	☐	☐
Carrying a small suitcase (with your affected limb)	☐	☐	☐	☐	☐
		X 1 =	X 2 =	X 3 =	X 4 =

SCORE = ____/80