

SHOULDER DATA COLLECTION FORM: POST-OPERATIVE

Today's Date: ___/___/___

Date of Injury: ___/___/___

Sex: Male Female

Dominant Arm: Right Left

Age: _____

Involved Shoulder: Left Right Bilateral

Surgery (check all that apply):

Date of Surgery: ___/___/___

Rotator Cuff Repair (Size: Small: <1cm Medium: 1-3cm Large: 3-5cm Massive: >5cm)

Labral Repair SLAP Bankart Instability Reconstruction SAI Decompression Other _____

Open Surgery Arthroscopic Surgery

Other symptoms (check all that apply even if unrelated)

Neck Thoracic Arm Elbow/Forearm Hand Soft Tissue Restriction: Location _____

Comorbidities:

Blood Pressure ___/___ Measured Patient Reported Height ___ft ___in, Weight ___lbs Measured Patient Reported

Smoker (circle one): Current Past Never Physical Activity: Meets Does not meet

CVD (patient/family history) DM (patient/family history) Pulmonary Disease (patient/family history)

No Comorbidities Reported Other Conditions: _____

Medications For: CV DM Pulm Disease Shoulder Pain Other musculoskeletal pain Other _____

Additional Information:

Scar Healing Satisfactory Delayed Cuff Atrophy Yes No Region _____ Abduction Pillow Used: Yes No

Sling (if issued) Start date ___/___/___ Stop date ___/___/___ Protocol Used Yes No (Attach Protocol)

List dates that each goal below was achieved (enter with month/day/year):

Sleeping throughout Night: ___/___/___ Begin AROM: ___/___/___ Begin Strengthening Rotator Cuff: ___/___/___

	Interventions				Elevation AROM	ER 90° ABD PROM	Hand to Neck	Hand to Scapula	Hand to Opposite Scapula	Resistive External Rotation	NPRS (0-10)	Quick DASH	GROC
	1	2	3	4									
Wk 1 Post-Op Date:										<input type="radio"/> Normal <input type="radio"/> Diminished <input type="radio"/> Unable			
Wk 2 Post-Op Date:										<input type="radio"/> Normal <input type="radio"/> Diminished <input type="radio"/> Unable			
Wk 6 Post-Op Date:										<input type="radio"/> Normal <input type="radio"/> Diminished <input type="radio"/> Unable			
Wk 8 Post-Op Date:										<input type="radio"/> Normal <input type="radio"/> Diminished <input type="radio"/> Unable			
Wk 12 Post-Op Date:										<input type="radio"/> Normal <input type="radio"/> Diminished <input type="radio"/> Unable			
D/C Date:										<input type="radio"/> Normal <input type="radio"/> Diminished <input type="radio"/> Unable			

Interventions:

- | | | |
|--------------------------------------|-----------------------------|-------------------------------|
| A. Patient education/instruction | I. Mob - Shoulder | R. Ultrasound |
| B. PROM - shoulder | J. Mob - Neck | S. Hot Packs |
| C. AROM - shoulder | K. Mob - T-spine/Ribs | T. Cryotherapy |
| D. Isometric strengthening exercises | L. Manip - Shoulder | U. Ionto |
| E. PREs - rotator cuff | M. Manip - Neck | V. Soft Tissue Mob - Shoulder |
| F. PREs - scapular muscles | N. Manip - T-Spine/Ribs | W. Soft Tissue Mob - Scapular |
| G. PREs - other | O. AROM/PROM - Spine | X. Soft Tissue Mob - Spine |
| H. Proprioception Exercises | P. E-Stim for pain | Y. Other: _____ |
| | Q. E-Stim for strengthening | |

Date of Initial PT Eval: ___/___/___ Last visit: ___/___/___ Total number visits: _____ Total wks in PT: _____

Last visit: Discharge Last Available

Primarily Examined by: CI Student Both Primarily Treated by: CI Student Both

Instructions

Dates: Use the format MM / DD / YYYY. If patient cannot recall the "Date of Symptom onset" specify the month, if they cannot recall the month, specify the year.

Sex: Check in the appropriate circle.

Age: Indicate the patient's age at the time of the first visit.

Involved Side and Dominant Arm: Check in the appropriate circle.

Injury: Check the appropriate circle for all surgical shoulder injuries that apply to the patient. More than one option may be selected.

Other Symptoms: Indicate if the patient has any other symptoms that may or may not be related to the current shoulder injury. Indicate "Neck" if the patient has symptoms anywhere from the suboccipital region through C7. Indicate "Thoracic" for any symptoms in the thoracic spine (T1 through L1) or in the rib cage. Indicate "Soft Tissue Symptoms" if patient has any symptoms of soft tissue including examples such as upper trapezius.

Comorbidities: Check the appropriate circles for any comorbidities which which the patient presents. More than one option may be selected.

Medications: Check the appropriate circles for all medications that the patient is currently taking. More than one option may be selected.

Additional Information: Indicate if scar healing was satisfactory. Scar healing is considered to be delayed if primary closure does not occur in the first 72 hours, if the wound remains red and inflamed or open after 3 weeks. Indicate if cuff atrophy was observed and in what region for example infraspinatus fossa or supraspinatus fossa. Cuff atrophy is defined as a observable difference in size of the rotator cuff muscles of the affected side compared to the unaffected side.

Additional Goals: Indicate the date that the patient begins to sleep through the night following their normal sleeping pattern. Indicate the date that active range of motion exercises are initiated and the date when rotator cuff strengthening exercises are initiated.

Interventions: For each week, choose from the interventions list A-Y, the four most relevant treatments used that week. Prioritize the interventions in the order believed to be most influential on the patient's recovery.

Elevation Active Range of Motion: Perform measure with subject standing and forearm positioned with thumb up. Shoulder is elevated in the scapular plane approximately 30 to 45 degrees anterior to the frontal plane. Use the following measurement procedure:

1. Center the fulcrum of the goniometer close to the acromial process.
2. Align the proximal arm with the midaxillary line of the thorax.
3. Align the distal arm with the lateral midline of the humerus, using the lateral epicondyle of the humerus for reference.
4. The patient's shoulder is actively moved into end-range flexion while the therapist guides the motion as necessary.
5. Measure the patient's total shoulder scaption at the end of their available range.

Shoulder External Rotation at 90° Abduction Passive Range of Motion: External Rotation of the shoulder is measured at 90 degrees of abduction. The subject is supine with the shoulder joint at 90 degrees of abduction.

Hand to Neck: (shoulder flexion and external rotation)*

0. Fingers to posterior midline neck with shoulder in full abduction and external rotation without wrist extension
1. Fingers reach midline of neck but do not have full abduction and/or external rotation
2. Fingers reach midline of neck, but with compensation by adduction in horizontal plane or by shoulder elevation
3. Fingers touch neck
4. Fingers do not reach neck

Hand to Scapula: (shoulder extension and internal rotation)†

0. Hand reaches behind trunk to opposite scapula or 5 cm beneath it in full internal rotation. Wrist is not laterally deviated
1. Hand almost reaches opposite scapula, 6-15 cm beneath it
2. Hand reaches opposite iliac crest
3. Hand reaches buttock
4. Subject cannot move hand behind trunk

Hand to Opposite Scapula: (shoulder horizontal adduction)‡

0. Hand reaches to spine of opposite scapula in full adduction without wrist flexion
1. Hand reaches to spine of the opposite scapula in full adduction
2. Hand passes midline of trunk
3. Hand cannot pass midline of trunk

Resisted External Rotation: Resisted external rotation in the scapular plane (30 to 45 degrees anterior to the frontal plane) is performed to assess overall rotator cuff strength. The patient is standing. The therapist places the patient's shoulder into neutral External Rotation in the scapular plane with approximately 15 degrees of abduction. The ability of the patient to hold the test position is first assessed. If the patient cannot hold this position, the 'unable' box is checked. If the patient can hold the test position, resistance is applied. If the patient cannot resist with the same force as the opposite arm, the 'diminished' box is checked. If the resistance is equal to the opposite side, the 'normal' box is checked.

Pain: The patient is asked to rate his or her worst pain over the past 24 hours on a scale from 0 (no pain) to 10 (worst imaginable pain).

QuickDASH: Each item on the QuickDASH is scored from 1-5 using the number values listed below. All 11 items must be reported in order to calculate a QuickDASH score. If all items are answered, the score is calculated by adding all of the scores together, dividing by 11, subtract 1 and multiply the result by 25. The QuickDASH should be performed at the initial visit, every 2 weeks, and at discharge.

Global Rating of Change: Enter the number -7 to +7 corresponding to the change reported by the patient using the GROCC Form.

Date of Initial PT Eval/Last Visit: Record the appropriate dates.

Total number visit: Indicate the total number of PT visits that have been included in data collection. Include visits with a PTA and/or ATC if these visits were performed in the PT clinic.

Total Weeks in PT: Provide the number of weeks of care the patient was followed for data collection.

Last Visit: Indicate if the last set of data recorded was associated with the discharge or was just the last set of data available.

Primarily Examined By / Treated By: Check the most appropriate box.