

Name _____

Upper Scan

☐ Verbal ConsentSpecial Questions

- ☐ Bilateral Arm Pain?
☐ Significant change in weight?
☐ Cough ☐ Sneeze ☐ Strain?
 Steroid use ☐ past ☐ present?

Cervical AROM with O/P ☐ Clear ☐ Further Testing IndicatedJaw AROM ☐ Clear ☐ Further Testing IndicatedShoulder Elevation with O/P ☐ Clear ☐ Further Testing Indicated ☐ Right ☐ LeftElbow AROM with O/P ☐ Clear ☐ Further Testing Indicated ☐ Right ☐ LeftWrist AROM with O/P ☐ Clear ☐ Further Testing Indicated ☐ Right ☐ LeftGrip ☐ Clear ☐ Further Testing Indicated ☐ Right ☐ LeftNeurological Testing (↑,↓,N)

Dermatomes	LT	Sharp/Dull	NT	Muscle Testing (__/5)	Right	Left
C2 Temporal/Occipital	_____	_____	_____	C2 Cervical Flexion	_____	_____
C3-4 Supraclavicular	_____	_____	_____	C3 Cervical Extension	_____	_____
C5 Lateral Arm	_____	_____	_____	C4 Scapular Elevation	_____	_____
C6 Lateral Forearm/Thumb	_____	_____	_____	C5 Shoulder Abduction	_____	_____
C7 Middle Finger	_____	_____	_____	C6 Wrist Extension	_____	_____
C8 Little Finger	_____	_____	_____	C7 Wrist Flexion	_____	_____
T1 Medial Lower Arm	_____	_____	_____	C8 Thumb Extension	_____	_____
				T1 Hand Intrinsic	_____	_____

Reflexes	Absent	Hypo	Normal	Hyper	NT
C5 Bicep	☐	☐	☐	☐	☐
C6 Brachioradialis	☐	☐	☐	☐	☐
C7 Tricep	☐	☐	☐	☐	☐

VA Testing ☐ Clear ☐ Further Testing RequiredTOS Testing ☐ Clear ☐ Further Testing RequiredULT Testing ☐ Clear ☐ Further Testing Required

Mass, Tone and general observation.

Signature_____/_____/_____
Date