Biceps Load Test

PATIENT INFORMATION

Full Name: _____ Date of Birth: _____ dd / mm / yyyy

Contact Number: _____

Address

Referring Physician: _____

MEDICAL HISTORY

Previous Shoulder Injuries

Relevant Medical Conditions

Current Medications

Known Allergies

Recent Surgeries (if any)

SUBJECTIVE ASSESSMENT

Onset of Pain

Pain Scale (0-10): _____

Type of pain

Aggravating Factors

Alleviating Factors

OBJECTIVE ASSESSMENT

Shoulder Range of Motion

Pain on Palpation

Strength Assessment (Out of 5): _____

SPECIAL TESTS

Biceps Load Test I

Biceps Load Test II

Speed's Test

Yergason's Test

Drop Arm Test

FINDINGS

Observations

Special Notes

INTERPRETATION

Interpretation

Test Outcome (Implications)

Recommendations

Overall Interpretation

SUMMARY & PLAN

Summary & Plan