Kim Test

PATIENT INFORMATION

Name: _____ Date of birth: _____ dd / mm / yyyy

Date of examination: _____ dd / mm / yyyy Referring physician: _____

CLINICAL HISTORY

Chief complaint:

History of present illness:

Relevant medical history:

PHYSICAL EXAMINATION

General inspection:

Range of motion:

Other relevant tests conducted:

KIM TEST FOR SHOULDER

Technique usedThe patient is positioned sitting upright.The arm was abducted to 90 degrees, then elevated obliquely at 45 degrees with axial loading.The examiner's position is behind the patient.

FINDINGS

Pain:

- [ ] Yes
- [ ] No

Location of pain: _____

Click/clunk:

- [ ] Yes
- [ ] No

Severity of symptoms:

- ◯ Mild
- ◯ Moderate
- ◯ Severe

Patient's response:

IMPRESSION (PRELIMINARY)

Positive for posteroinferior labral lesion:

- [ ] Yes
- [ ] No

Suspected type of lesion (if applicable):

ADDITIONAL NOTES

Specify below:

Signature of examiner:
Date: _____ dd / mm / yyyy