# Labral Tear Test

## PATIENT INFORMATION

Patient Name: _____ Age: _____

Gender: _____ Medical Record Number: _____

## MEDICAL HISTORY

Relevant Medical History

Previous Shoulder Injuries/Surgeries

Current Medications

Allergies

## SYMPTOMS ASSESSMENT

Duration of Symptoms: _____

**Pain Description:**

Scale: _____ Location: _____

Triggering Activities

Range of Motion Limitations

Functional Limitations

Other Symptoms

## PHYSICAL EXAMINATION

Visual Inspection

Palpation

Range of Motion Testing

## SPECIAL TESTS FOR LABRAL TEAR:

O'Brien's Test

Biceps Load Test II

Anterior Slide Test

Other Tests:

Findings

## IMAGING AND DIAGNOSTIC TESTS

**X-Ray:**

Findings

**MRI:**

Findings

**Arthroscopy (if applicable):**

Findings

Other Test:

## DIAGNOSIS

Preliminary Diagnosis

Type of Labral Tear (if confirmed)

Severity

## TREATMENT PLAN

**Conservative Management:**

Physical Therapy

Medications

Activity Modifications

**Surgical Options:**

Recommended Procedure

Expected Outcomes

Follow-Up Schedule

## CLINICIAN'S NOTES AND OBSERVATIONS

Notes and Observations

## PATIENT EDUCATION AND GUIDANCE

Information Provided

Patient's Understanding and Questions

Clinician's Signature

Date: _____ dd / mm / yyyy