Muscular Strength Test

Name: _____ Date: _____ dd / mm / yyyy

Age: _____ Gender: _____

Brief Medical History:

Note: Score each joint movement separately using the Oxford Scale (0-5). Record initial and current scores to track progress. Score 0: No muscle contraction Score 1: Visible muscle contraction with no movement Score 2: Movement possible but not against gravity Score 3: Movement possible against gravity but not resistance Score 4: Movement possible against some resistance but weaker than normal Score 5: Normal strength

UPPER EXTREMITIES STRENGTH ASSESSMENT

Movement: Shoulder Flexion

- ◯ 0
- ◯ 1
- ◯ 2
- ◯ 3
- ◯ 4
- ◯ 5

Movement: Shoulder Extension

- ◯ 0
- ◯ 1
- ◯ 2
- ◯ 3
- ◯ 4
- ◯ 5

Movement: Shoulder Abduction

- ◯ 0
- ◯ 1
- ◯ 2
- ◯ 3
- ◯ 4
- ◯ 5

Movement: Shoulder Horizontal Adduction

- ◯ 0
- ◯ 1
- ◯ 2
- ◯ 3
- ◯ 4
- ◯ 5

Movement: Scapula Elevation

- ◯ 0
- ◯ 1
- ◯ 2
- ◯ 3
- ◯ 4
- ◯ 5

Movement: Scapular Retraction/Adduction

- ◯ 0
- ◯ 1
- ◯ 2
- ◯ 3
- ◯ 4
- ◯ 5

Movement: Elbow Flexion

- ◯ 0
- ◯ 1
- ◯ 2
- ◯ 3
- ◯ 4
- ◯ 5

Movement: Wrist Flexion

- ◯ 0
- ◯ 1
- ◯ 2
- ◯ 3
- ◯ 4
- ◯ 5

Movement: Wrist Extension

- ◯ 0
- ◯ 1
- ◯ 2
- ◯ 3
- ◯ 4
- ◯ 5

LOWER EXTREMITIES STRENGTH ASSESSMENT

Movement: Hip Flexion

- ◯ 0
- ◯ 1
- ◯ 2
- ◯ 3
- ◯ 4
- ◯ 5

Movement: Hip Extension

- ◯ 0
- ◯ 1
- ◯ 2
- ◯ 3
- ◯ 4
- ◯ 5

Movement: Hip Abduction

- ◯ 0
- ◯ 1
- ◯ 2
- ◯ 3
- ◯ 4
- ◯ 5

Movement: Hip Adduction

- ◯ 0
- ◯ 1
- ◯ 2
- ◯ 3
- ◯ 4
- ◯ 5

Movement: Hip Internal Rotation

- ◯ 0
- ◯ 1
- ◯ 2
- ◯ 3
- ◯ 4
- ◯ 5

Movement: Knee Flexion

- ◯ 0
- ◯ 1
- ◯ 2
- ◯ 3
- ◯ 4
- ◯ 5

Movement: Knee Extension

- ◯ 0
- ◯ 1
- ◯ 2
- ◯ 3
- ◯ 4
- ◯ 5

Movement: Plantarflexion

- ◯ 0
- ◯ 1
- ◯ 2
- ◯ 3
- ◯ 4
- ◯ 5

Movement: Dorsiflexion

- ◯ 0
- ◯ 1
- ◯ 2
- ◯ 3
- ◯ 4
- ◯ 5

Movement: Ankle Eversion

- ◯ 0
- ◯ 1
- ◯ 2
- ◯ 3
- ◯ 4
- ◯ 5

Movement: Ankle Inversion

- ◯ 0
- ◯ 1
- ◯ 2
- ◯ 3
- ◯ 4
- ◯ 5

HEALTH PROFESSIONAL'S OBSERVATIONS, RECOMMENDATIONS, AND NOTES

Health Professional's Observations, Recommendations, and Notes

Name of Health Professional: _____ **Name of Practice:** _____