



## CERVICAL EVALUATION FORM

Date:

Pt Name:

Pt number:

Diagnosis:

Referred by:

Visit #:

Time in:

Time out:

Billable units:

### **Patient Information:**

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Patient Profile:

Chief Complaint:

Account of Current Condition:

History of present injury:

Current Symptoms:

*Location:*

*Onset:*

*Character:*

*Intensity:*

*Duration:*

*Aggravating Factors:*

*Alleviating Factors:*

*24 hour behavior:*

PMH:

Medication/Allergies:

Current Function %:

Standardized Functional Questionnaire:

Modified Oswestry:

NDI:

Personal and Environmental Factors:

Activity:

Occupation:

Patient Goals:

### **Systems Review:**

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Cardiopulmonary:

Neuromuscular:

Integumentary:

Musculoskeletal:



**Tests and Measures:**

(consider the Canadian C-spine rules through-out your examination)

Observation:

Joint Clearing:

Precautionary Tests:

- Vertebral Artery Test:
- Dizziness Test:
- Transverse Ligament Test:
- Lateral Shear Test for AA:
- Sharp-Purser Test:
- Lateral Flexion and Rotational Alar Ligament Tests:

ROM:

	AROM		PROM		End Feel	
Flexion						
Extension						
	L	R	L	R	L	R
SB						
Rotation						

Resisted Tests:

Flexibility:

Neurologic Screen:

	Sensation		Reflexes		Motor	
	L	R	L	R	L	R
C1						
C2						
C3						
C4						
C5						
C6						
C7						
C8						
T1						

Pathologic Reflexes:

Special Tests:

- |  |  |
|--|--|
| <input type="checkbox"/> Adson's Test:                           | <input type="checkbox"/> Bakody's Sign:        |
| <input type="checkbox"/> Costoclavicular Test:                   | <input type="checkbox"/> ULTT 1:               |
| <input type="checkbox"/> Modified Wrigh(Allen's)Test:            | <input type="checkbox"/> ULTT 2:               |
| <input type="checkbox"/> Wright Test:                            | <input type="checkbox"/> ULTT 3:               |
| <input type="checkbox"/> Roos Test:                              | <input type="checkbox"/> ULTT 4:               |
| <input type="checkbox"/> Shoulder Girdle Passive Elevation Test: | <input type="checkbox"/> Slump Test:           |
|  | <input type="checkbox"/> Valsalva's Test:      |
| <input type="checkbox"/> Cervical Compression Test:              | <input type="checkbox"/> Swallowing Test:      |
| <input type="checkbox"/> Spurlings Test:                         | <input type="checkbox"/> Cervicogenic HA Test: |
| <input type="checkbox"/> Cervical Distraction Test:              |  |



Joint Mobility:

Palpation:

Functional Tests:

Today's Intervention:

**Evaluation:**

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Summary:

Impairments:

Functional Limitations:

Response to Today's Intervention:

**Plan of Care:**

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Outcomes:

STG:

LTG:

Prognosis:

Intervention Plan:

**Informed Consent:**

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( Patient or  Guardian) has been informed of all evaluation findings and treatment plans and agrees to participate in Physical Therapy services and plans as outline, including the given HEP.

Sign: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Date: