DIAGNOSTIC TESTING WORKSHEET

Patent Name : ________________________________ **Patient Claim Number:** _____________________

Date : ____________________

Cervical Spine ROM											Pain start or	
Patient Measurements	Normal	#1	#2	#3	Active	#1	#2	#3	Passive	% Normal	increase pt.	Pain
Flexion (Flex)	50				0				0	0%		
Extension (Ext)	60				0				0	0%		
Rt Lateral Flex (RLF)	45				0				0	0%		
Left Lateral Flex (LLF)	45				0				0	0%		
Rt Rotation (Rt. Rot)	80				0				0	0%		
Lt Rotation (Lt. Rot.)	80				0				0	0%		

Date : ____________________

Lumbar Spine ROM											Pain start or	
Patient Measurements	Normal	#1	#2	#3	Active	#1	#2	#3	Passive	% Normal	increase pt.	Pain
Flexion (Flex)	90				0				0	0%		
Extension (Ext)	25				0				0	0%		
Rt Lateral Flex (RLF)	25				0				0	0%		
Left Lateral Flex (LLF)	25				0				0	0%		
Rt Rotation (Rt. Rot)	20				0				0	0%		
Lt Rotation (Lt. Rot.)	20				0				0	0%		

Date : ____________________

Muscle Testing

Grip Strength: 1. _____ **2.** _____ **3.** _____

UPPER BODY	Force	Time (Sec)
Cervical Flexion,SCM,		
Cervical Ext. Upper TTrap.C3, C4		

	Left Force	Time (Sec)	Right Force	Time (Sec.)	% Diff.	% Adjusted Diff. *
Lateral Cerv. FlexScal: C4-C8					0.00%	0.00%
Deltoid: C5, C6					0.00%	0.00%
Biceps: C5, C6					0.00%	0.00%
Triceps: C7, C8					0.00%	0.00%
Flex Carp Rad:C6,C7					0.00%	0.00%
Extensor Carp Rad: C6-C7					0.00%	0.00%
Finger Flexion: C7, C8, T1					0.00%	0.00%
Finger Ext: C7, C8, T1					0.00%	0.00%

LOWER BODY	Left Force	Time (Sec)	Right Force	Time (Sec.)	% Diff.	% Adjusted Diff. *
Ilio-Psoas: L2, L3					0.00%	0.00%
Glut Max: L5, S1					0.00%	0.00%
Hamstrings: L5, S2					0.00%	0.00%
Quadriceps: L5, S2					0.00%	0.00%
Tibialis: L4, L5					0.00%	0.00%
Gastroc: S1, S2					0.00%	0.00%

Comments:

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Date: __________

Algometer Exam			*Thermeter Exam*	
Left	**Right**		**Left**	**Right**
		C1		
		C2		
		C3		
		C4		
		C5		
		C6		
		C7		
		T1		
		T2		
		T3		
		T4		
		T5		
		T6		
		T7		
		T8		
		T9		
		T10		
		T11		
		T12		
		L1		
		L2		
		L3		
		L4		
		L5		

Date: __________

Date: __________

FibroMyalgia Testing

Anterior

Control Pt	**Forehead**	

Right	Left	
		Low Cervical
		2nd Rib
		Lat Epicond
		Medial Knee
Control Pt	**Lt Thumb**	

Posterior

Left	Right	
		Occiput
		Trapezius
		Supraspinatus
		Gluteal
		Greater Troch
Control Pt	**Rt Forearm**	

Patient:		
Height:		
Weight:		
Gender:		
RT/ LT hand		
DOB		

Date: __________

Male Body-Composition Report

Name:			Age:			Date:	
Weight:			Height:			Pat. Num:	

Skin-Fold Measurements in Millimeters:

Triceps:		mm
Suprailliac (Hip)		mm
Umbilicus (Stomach)		mm
Thigh:		mm
Sum of Measurements		mm

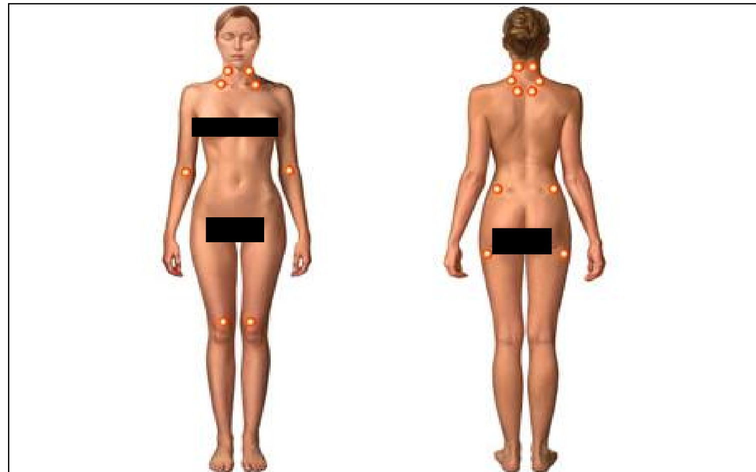
Date: __________

Female Body-Composition Report

Name:			Age:			Date:	
Weight:			Height:			Pat. Num:	

Skin-Fold Measurements in Millimeters:

Triceps:		mm
Suprailliac (Hip)		mm
Umbilicus (Stomach)		mm
Thigh:		mm
Sum of Measurements		mm



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