

DIAGNOSTIC TESTING WORKSHEET

Patent Name : _____

Patient Claim Number: _____

Date : _____

Cervical Spine ROM												
Patient Measurements	Normal	#1	#2	#3	Active	#1	#2	#3	Passive	% Normal	Pain start or 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												
Patient Measurements	Normal	#1	#2	#3	Active	#1	#2	#3	Passive	% Normal	Pain start or 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

UPPER BODY

Cervical Flexion, SCM,
Cervical Ext. Upper TTrap. C3, C4

Force	Time (Sec)

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

Lateral Cerv. Flex Scal: C4-C8
Deltoid: C5, C6
Biceps: C5, C6
Triceps: C7, C8
Flex Carp Rad: C6, C7
Extensor Carp Rad: C6-C7
Finger Flexion: C7, C8, T1
Finger Ext: C7, C8, T1

Left Force	Time (Sec)	Right Force	Time (Sec)	% Diff.	Adjusted Diff. *
				0.00%	0.00%
				0.00%	0.00%
				0.00%	0.00%
				0.00%	0.00%
				0.00%	0.00%
				0.00%	0.00%

LOWER BODY

Ilio-Psoas: L2, L3
Glut Max: L5, S1
Hamstrings: L5, S2
Quadriceps: L5, S2
Tibialis: L4, L5
Gastroc: S1, S2

Left Force	Time (Sec)	Right Force	Time (Sec)	% Diff.	Adjusted Diff. *
				0.00%	0.00%
				0.00%	0.00%
				0.00%	0.00%
				0.00%	0.00%
				0.00%	0.00%

Comments:

Date: _____

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: _____

FibroMyalgia Testing

Anterior

Control Pt Forehead

Right	Left	Low Cervical
<input type="text"/>	<input type="text"/>	2nd Rib
<input type="text"/>	<input type="text"/>	Lat Epicond
<input type="text"/>	<input type="text"/>	Medial Knee

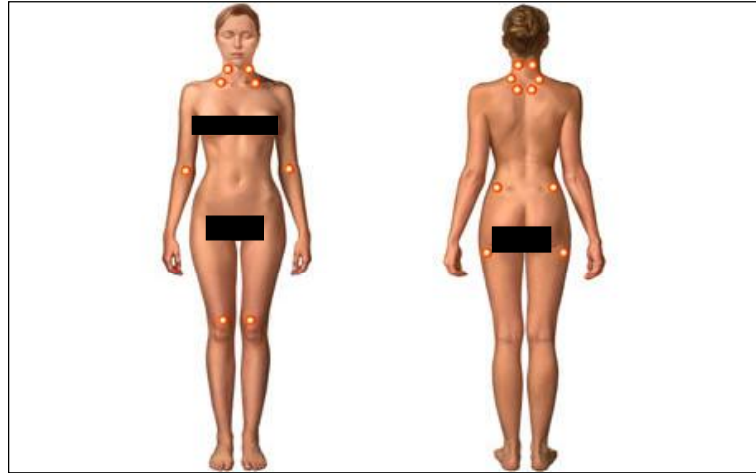
Control Pt Lt Thumb

Posterior

Left	Right	Occiput
<input type="text"/>	<input type="text"/>	Trapezius
<input type="text"/>	<input type="text"/>	Supraspinatus
<input type="text"/>	<input type="text"/>	Gluteal
<input type="text"/>	<input type="text"/>	Greater Troch

Control Pt Rt Forearm

Patient:	<input type="text"/>
Height:	<input type="text"/>
Weight:	<input type="text"/>
Gender:	<input type="text"/>
RT/ LT hand	<input type="text"/>
DOB	<input type="text"/>



Date: _____

Male Body-Composition Report

Name:	<input type="text"/>	Age:	<input type="text"/>	Date:	<input type="text"/>
Weight:	<input type="text"/>	Height:	<input type="text"/>	Pat. Num:	<input type="text"/>

Skin-Fold Measurements in Millimeters:

Triceps:	<input type="text"/>	mm
Suprailliac (Hip)	<input type="text"/>	mm
Umbilicus (Stomach)	<input type="text"/>	mm
Thigh:	<input type="text"/>	mm
Sum of Measurements	<input type="text"/>	mm

Date: _____

Female Body-Composition Report

Name:	<input type="text"/>	Age:	<input type="text"/>	Date:	<input type="text"/>
Weight:	<input type="text"/>	Height:	<input type="text"/>	Pat. Num:	<input type="text"/>

Skin-Fold Measurements in Millimeters:

Triceps:	<input type="text"/>	mm
Suprailliac (Hip)	<input type="text"/>	mm
Umbilicus (Stomach)	<input type="text"/>	mm
Thigh:	<input type="text"/>	mm
Sum of Measurements	<input type="text"/>	mm