



THE MCKENZIE INSTITUTE UPPER EXTREMITIES ASSESSMENT

Date _____

Name _____ Sex M / F

Address _____

Telephone _____

Date of Birth _____ Age _____

Referral: GP / Orth / Self / Other _____

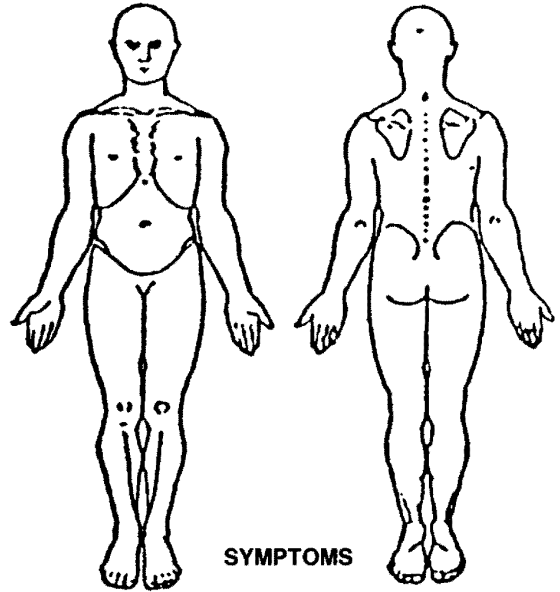
Work: Mechanical stresses _____

Leisure: Mechanical stresses _____

Functional Disability from present episode _____

Functional Disability score _____

VAS Score (0-10) _____



HISTORY

Handedness: Right / Left

Present Symptoms _____

Present since _____ *Improving / Unchanging / Worsening*

Commenced as a result of _____ *Or No Apparent Reason*

Symptoms at onset _____ *Paraesthesia: Yes / No*

Spinal history _____ *Cough / Sneeze +ve / -ve*

Constant symptoms: _____ Intermittent Symptoms: _____

Worse	<i>bending</i>	<i>sitting</i>	<i>turning neck</i>	<i>dressing</i>	<i>reaching</i>	<i>gripping</i>
	<i>am / as the day progresses / pm</i>		<i>when still / on the move</i>	<i>Sleeping: prone / sup / side R / L</i>		
	<i>Other</i> _____					
Better	<i>bending</i>	<i>sitting</i>	<i>turning neck</i>	<i>dressing</i>	<i>reaching</i>	<i>gripping</i>
	<i>am / as the day progresses / pm</i>		<i>when still / on the move</i>	<i>Sleeping: prone / sup / side R / L</i>		
	<i>other</i> _____					

Continued use makes the pain: *Better* *Worse* *No Effect* *Disturbed night* Yes / No

Pain at rest Yes / No Site: *Neck / Shoulder / Elbow / Wrist / Hand*

Other Questions: *Swelling* *Catching / Clicking / Locking* *Subluxing*

Previous episodes _____

Previous treatments _____

General health: *Good / Fair / Poor* _____

Medications: *Nil / NSAIDS / Analg / Steroids / Anticoag / Other* _____

Imaging: Yes / No _____

Recent or major surgery: Yes / No _____ Night pain: Yes / No _____

Accidents: Yes / No _____ Unexplained weight loss: Yes / No _____

Summary *Acute / Sub-acute / Chronic* *Trauma / Insidious Onset*

Sites for physical examination *Neck / Shoulder / Elbow / Wrist / Hand* *Other:* _____

EXAMINATION

POSTURE

Sitting *Good / Fair / Poor* Correction of Posture: *Better / Worse / No Effect / NA* Standing: *Good / Fair / Poor*
 Other observations: _____

NEUROLOGICAL: *NA / Motor / Sensory / Reflexes / Dural* _____

BASELINES (pain or functional activity): _____

EXTREMITIES *Shoulder / Elbow / Wrist / Hand*

MOVEMENT LOSS	Maj	Mod	Min	Nil	Pain
Flexion					
Extension					
Supination					
Pronation					

	Maj	Mod	Min	Nil	Pain
Adduction / Ulnar Deviation					
Abduction / Radial Deviation					
Internal Rotation					
External Rotation					

Passive Movement (+/- over pressure) (note symptoms and range): _____

	PDM	ERP

Resisted Test Response (pain) _____

Other Tests _____

SPINE

Movement Loss _____

Effect of repeated movements _____

Effect of static positioning _____

Spine testing *Not relevant / Relevant / Secondary problem* _____

Baseline Symptoms _____

Repeated Tests	Symptom Response		Mechanical Response	
	During – Produce, Abolish, Increase, Decrease, NE	After – Better, Worse, NB, NW, NE	Effect – ↑ or ↓ ROM, strength or key functional test	No Effect
Active / Passive movement, resisted test, functional test				
Effect of static positioning				

PROVISIONAL CLASSIFICATION

Dysfunction – Articular _____
 Derangement _____
 Other _____

Extremities

Spine
 Contractile _____
 Postural _____
 Uncertain _____

PRINCIPLE OF MANAGEMENT

Education _____ Equipment Provided _____
 Exercise and Dosage _____
 Treatment Goals _____