

FROZEN SHOULDER

Nonoperative Physical Therapy Protocol



Stanford
MEDICINE

Dear Colleague,

I appreciate your partnership in the rehabilitation of this very special patient of ours. I have instructed the patient that you will be using this protocol. My belief is that the biggest predictor of success is what the patient does at home and consistently. **They should view you not just as a therapist but as a highly educated and skilled teacher** and the patient *must* be an active participant in the rehab process.

To facilitate this, I have included the protocol I would like the patient to focus on at each stage of their rehab. The patient has also been given a home exercise program to do alongside their therapy. I would be grateful if you could help teach them to perform those exercises correctly and encourage them to stay consistent.

With your help and the active participation of our patient, I know we can have another fantastic shoulder.

Please do not hesitate to reach out directly to me and my team with any questions at any time.

Respectfully,



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We suggest guiding progression by pain rather than elapsed time. The patient has a home stretching program to perform three times daily. The recommendations below are meant to complement your clinical judgment.

PAIN LEVEL	HOW IT PRESENTS	STRETCH INTENSITY	MOBILIZATION
High Pain 7-10	- Night pain. - Pain reached before end range. - Often the freezing stage.	- Work strictly within a pain-free arc. - Do not add pain.	- Low grade only. - Avoid end-range and capsular stretching.
Moderate Pain 4-6	- Pain at or near end range. - Stiffness becoming the dominant complaint.	Gradually increase hold duration and intensity as tolerated.	Progress toward end range as symptoms allow.
Low Pain 0-3	- Pain only at end range. - Stiffness is the limiting factor.	- Longer holds. - Mild discomfort during stretch is acceptable.	End-range and higher-grade mobilization appropriate.



Technique Notes

- 1 We favor **gentle PROM initially**, within a pain-free arc, using modalities to facilitate stretch rather than forcing through pain.
- 2 **Isolating glenohumeral motion** by blocking scapulothoracic substitution through the 0 to 80 degree arc of flexion and abduction is helpful.
- 3 We suggest prioritizing **internal and external rotation at 90 degrees of abduction** in supine, including sleeper stretch positioning.
- 4 Consider applying heat or other modalities while the shoulder is held in a **comfortable end-range stretch** rather than resting at the side.
- 5 **Rotator cuff and scapular stabilization** can begin at 0 degrees and progress to 45 and then 90 degrees as tolerated pain-free.
- 6 **Maitland or combined mobilization** approaches work well, with posterior glides for restoring external rotation.



Precautions

- ! We recommend **avoiding aggressive end-range manipulation or forceful passive stretching**, particularly during the painful phase, as it tends to worsen symptoms.
- ! We suggest **holding resisted strengthening** until pain is no longer limiting motion.
- ! **Patients with diabetes** are more likely to plateau and to retain residual stiffness. Slower progression is expected and is not a failure of the program.



What to Track, and When to Tell Us

- We find it helpful to track passive range of motion in all planes at the initial evaluation and reassessments, with isolated glenohumeral abduction and external rotation where feasible.
- **Please let us know** if the patient has not gained at least 10 degrees of isolated glenohumeral abduction and external rotation over the first two months.
- **Please let us know** if pain is escalating rather than settling or if the patient cannot tolerate the home program.



Suggested discharge criteria

- ✓ Functional range of motion sufficient for occupational and daily demands.
- ✓ Pain controlled and not limiting activity or sleep.
- ✓ Patient independent with a maintenance home program.