

OSTEOPATHIC MUSCULOSKELETAL EXAMINATION OF THE HOSPITALIZED PATIENT

Subjective: _____

Vitals: T _____ B/P _____ H _____ R _____ Pulse ox _____ Date/Time: _____

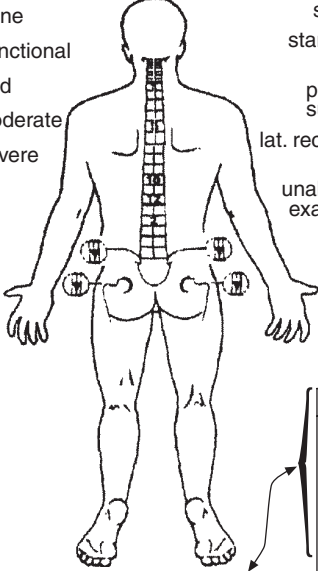
Required

Ant./Post. Spinal Curves:	I	N	D
Cervical Lordosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thoracic Kyphosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lumbar Lordosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

I = increased; N = normal; D = decreased.

Scoliosis (Lateral Spinal Curves)

- | | |
|-------------------------------------|--|
| <input type="checkbox"/> None | sitting <input type="checkbox"/> |
| <input type="checkbox"/> Functional | standing <input type="checkbox"/> |
| <input type="checkbox"/> Mild | prone/supine <input type="checkbox"/> |
| <input type="checkbox"/> Moderate | lat. recumb. <input type="checkbox"/> |
| <input type="checkbox"/> Severe | unable to examine <input type="checkbox"/> |



For Coding Purposes Only

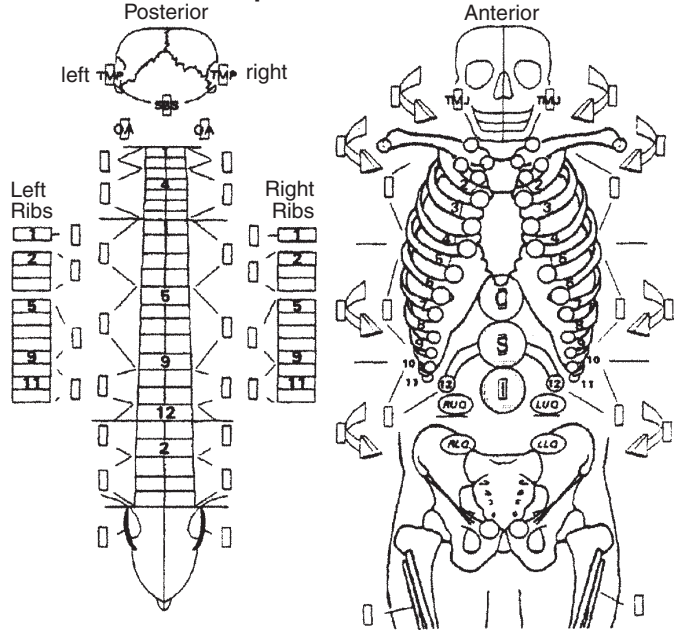
Assessment Tools:

- T = Tenderness
- A = Asymmetry
- R = Restricted Motion
 - Active
 - Passive
- T = Tissue Texture Change

Severity Key:

- 0 = No SD or background (BG) levels
- 1 = Minor TART more than BG levels
- 2 = TART obvious (R & T esp) +/- symptoms
- 3 = Symptomatic, R and T very easily found, "key lesion"

Optional Worksheet



Abbreviation Key:

- | | |
|---------------------------|-----------------------------|
| OA Occipitoatlantal joint | TMJ Temporo-mandibular Jnt. |
| Sympathetic ganglia: | TMP Temporal bone |
| C Celiac | SBS Sphenobasilar symphysis |
| S Superior Mesenteric | |
| I Inferior Mesenteric | |

Region Evaluated	Severity				Specific of Major Somatic Dysfunctions	Major Correlations with:
	0	1	2	3		
Head	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Traumatic <input type="checkbox"/> Rheumatological
Neck	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Orthopedic <input type="checkbox"/> EENT
Thoracic T1 - 4	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Neurological <input type="checkbox"/> Cardiovascular
T5 - 9	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Viscerosomatic <input type="checkbox"/> Pulmonary
T10 - 12	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Primary Ms-Skeletal <input type="checkbox"/> Gastrointestinal
Lumbar	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Activities of Daily Living <input type="checkbox"/> Genitourinary
Pelvis/Sacrum	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Other _____ <input type="checkbox"/> Congenital
Pelvis/Innominate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		OMM Treatment Plan (include method, dose, frequency, and/or duration, as appropriate): _____ _____
Extremity (lower) R	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
L	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Extremity (upper) R	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Signatures: MS-III/MS-IV: _____ Intern/Resident: _____ Attending: _____
L	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		

ADDRESSOGRAPH



**Downey Regional
Medical Center**
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