OSTEOPATHIC MUSCULOSKELETAL EXAMINATION

Patient's Name:

Subjective: _____

_____

_____

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

Initial Visit ☐ **F/u** ☐ **Pain level** _____ / 10 **WT:** _____ **HT:** _____

Required

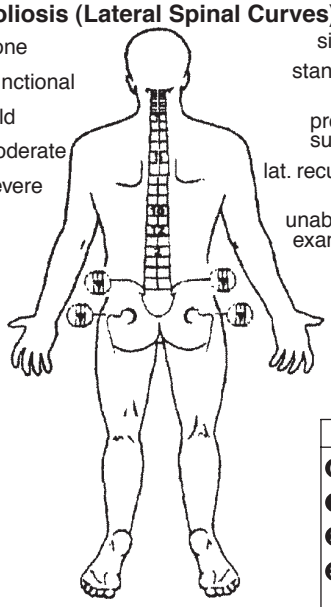
For Coding Purposes Only

Ant./Post. Spinal Curves:	I	N	D
Cervical Lordosis	☐	☐	☐
Thoracic Kyphosis	☐	☐	☐
Lumbar Lordosis	☐	☐	☐

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

Scoliosis (Lateral Spinal Curves)

☐ None
☐ Functional
☐ Mild
☐ Moderate
☐ Severe



sitting ☐
standing ☐
prone/supine ☐
lat. recumb. ☐
unable to examine ☐

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"

Meds:

Region Evaluated	Severity 0	1	2	3	Specific of Major Somatic Dysfunctions
Head	☐	☐	☐	☐	
Neck	☐	☐	☐	☐	
Thoracic T1 - 4	☐	☐	☐	☐	
T5 - 9	☐	☐	☐	☐	
T10 - 12	☐	☐	☐	☐	
Lumbar	☐	☐	☐	☐	
Pelvis/Sacrum	☐	☐	☐	☐	
Pelvis/Innominate	☐	☐	☐	☐	
Extremity (lower) R	☐	☐	☐	☐	
Extremity (lower) L	☐	☐	☐	☐	
Extremity (upper) R	☐	☐	☐	☐	
Extremity (upper) L	☐	☐	☐	☐	
Ribs	☐	☐	☐	☐	
Other	☐	☐	☐	☐	

Neuro:
DTR _ / 4 MS _ / 5 _____

Major Correlations with:

Traumatic	Orthopedic	Neurological
Primary Mus-Skl	ADLs	Rheumatological
Cardiovascular	Pulmonary	Gastrointestinal
Viscerosomatic	Congenital	
EENT	Other	
Genitourinary		

Assessment: Head/cranial somatic dysfunction 736.0

Cervical	739.1	Ribs: 739.8	
Thoracic	739.2	Abd / Other 739.9	
Lumbar	739.3		_____
Sacral	739.4		_____
Pelvic	739.5		_____
Lower Extremity	739.6		_____
Upper Extremity	739.7		_____

Improved ☐ Unchanged ☐ Worse ☐

Comments: _____

_____

_____

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_____

_____

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_____

_____

_____

Treatment time: _____ min, F/u appt _____

Plan:

OMT Performed

			Procedure Codes:		
ART	BMT		1-2	Reg	98925
ST	MFR	ME	3-4	Reg	98926
ART	SCS	HVLA	5-6	Reg	98927
BLT	BD	FPR	7-8	Reg	98928
CR	VIS	LYMPH	> 9	Reg	98929

Patient/Guardian explained the risks and benefits of OMT, and consented to treatement. ☐
Exercise plan given ☐
Nutritional advise given ☐
Smoking cessation counseling ☐
Compliance with home exercise program ___%
Post treatment pain level ___/10

_____

Signatures:

Intern / Resident: _____

Attending: _____