

# OSTEOPATHIC MUSCULOSKELETAL EXAMINATION OF THE HOSPITALIZED PATIENT

Subjective: \_\_\_\_\_

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

### Required

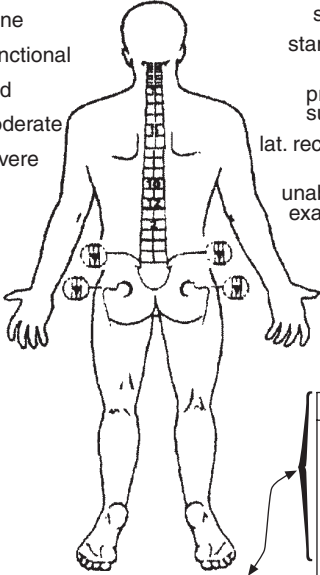
**Ant./Post. Spinal Curves:**

Cervical Lordosis	I	N	D
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

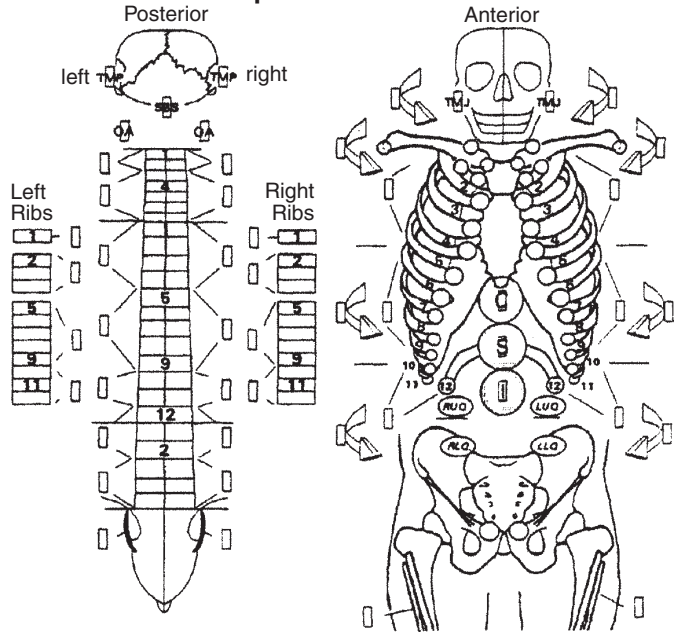
### Assessment Tools:

- 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 <span style="float: right;"><input type="checkbox"/> Rheumatological</span>
Neck	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Orthopedic <span style="float: right;"><input type="checkbox"/> EENT</span>
Thoracic T1 - 4	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Neurological <span style="float: right;"><input type="checkbox"/> Cardiovascular</span>
T5 - 9	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Viscerosomatic <span style="float: right;"><input type="checkbox"/> Pulmonary</span>
T10 - 12	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Primary Ms-Skeletal <span style="float: right;"><input type="checkbox"/> Gastrointestinal</span>
Lumbar	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Activities of Daily Living <span style="float: right;"><input type="checkbox"/> Genitourinary</span>
Pelvis/Sacrum	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Other _____ <span style="float: right;"><input type="checkbox"/> Congenital</span>
Pelvis/Innominate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<b>OMM Treatment Plan</b> (include method, dose, frequency, and/or duration, as appropriate): _____ _____
Extremity (lower) R	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Extremity (lower) 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"/>		<b>Signatures:</b> MS-III/MS-IV: _____ Intern/Resident: _____ Attending: _____
Extremity (upper) 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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