

# Single Organ System Musculoskeletal Examination

Office of: \_\_\_\_\_

Patient's Name: \_\_\_\_\_ Date: \_\_\_\_\_ Wt. \_\_\_\_\_ Ht. \_\_\_\_\_

For office only: \_\_\_\_\_

Sex:  Male  Female

Age: \_\_\_\_\_ BP: \_\_\_\_\_

Positions for Examinations

\* Vital Signs: (3 of 7 recorded) Resp. \_\_\_\_\_ Pulse \_\_\_\_\_

Reg.  Irreg.



## \* Build, Posture, Gait and Station:

Body type  Endo  Meso  Ecto  
 Posture  Excl  Fair  Poor  
 Gait  Symt  Antg  Tndb

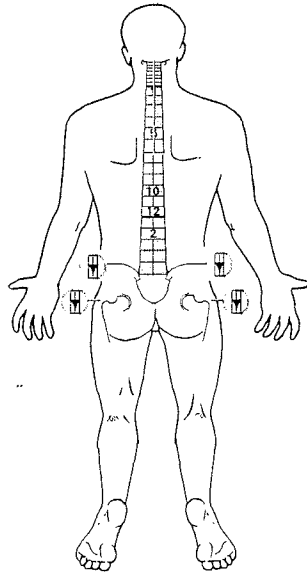
## Ant./Post. Spinal Curves: I N D

Cervical Lordosis     
 Thoracic Kyphosis     
 Lumbar Lordosis

I = Increased; N = normal; D = decreased

## Scoliosis (Lateral Spinal Curves)

None  Sitting  
 Functional  Standing  
 Mild  Prone/Supine  
 Moderate  Unable to examine  
 Severe



## Notes:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

## General Appearance

Normal:  Y  N

## \*Cardiovascular: Normal by:

Observation  Y  N

Palpation

## \*Lymphatics:

Palpable nodes  Y  N

## \*Neurologic:

Coordination intact  Y  N

Sensory intact  Y  N

## Psychiatric:

Sensory intact  Y  N

Oriented --to time

--to place

--to person

--Good mood & affect

Short Leg? Right  1/8  1/4  1/2  
 Equal  Left  1/8  1/4  1/2

## Cranial Dysfunction:

Rate \_\_\_\_\_  Good  Fair  Poor Amplitude  Good  Fair  Poor

Sidebending/Rotation  Right  Left SBS Compr.  Y  N Frontal Compr.  Y  N

Lateral Strain  Right  Left L Temp.  Held  Int. Rot.

Vertical Strain  Superior  Inferior  Locked  Ext. Rot.

R Temp.  Held  Int. Rot.

Locked  Ext. Rot.

## Level of GMS

- 2 = 1-5 elements
- 3 = 6+ elements
- 4 = 2+ from each of 6 areas
- 5 = all elements that are starred = \*

## \* Skin: Inspection and/or Palpation is normal in: (4 of 6 recorded)

Head and Neck  R. Upper Extremity  R. Lower Extremity  
 Trunk  L. Upper Extremity  L. Lower Extremity

Methods Used to Examine T  A  R  passive  active T  Severity Scale:   
 0 No SD or background (BG) levels 2 Obvious TART (esp. R and T), +/- symptoms  
 1 More than BG levels, minor TART 3 Key lesions, symptomatic, R and T stand out

Region Evaluated	Severity				Somatic Dysfunctions and Other Systems MS / SNS / PNS / LYM. / CV / RESP. / GI / FAS. / etc	OMT		Treatment Method (Circle Treatment Methods Used)	Response			
	0	1	2	3		Yes	No		R	I	U	W
1 Head and Neck	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	ART / BLT / CR / CS / DIR / FPR / HVLA IND / INR / LAS / ME / MFR / ST / VIS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thoracic T1-4	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	ART / BLT / CR / CS / DIR / FPR / HVLA IND / INR / LAS / ME / MFR / ST / VIS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
T5-9	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	ART / BLT / CR / CS / DIR / FPR / HVLA IND / INR / LAS / ME / MFR / ST / VIS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
T10-12	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	ART / BLT / CR / CS / DIR / FPR / HVLA IND / INR / LAS / ME / MFR / ST / VIS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2 Ribs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	ART / BLT / CR / CS / DIR / FPR / HVLA IND / INR / LAS / ME / MFR / ST / VIS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lumbar	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	ART / BLT / CR / CS / DIR / FPR / HVLA IND / INR / LAS / ME / MFR / ST / VIS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sacrum/Pelvis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	ART / BLT / CR / CS / DIR / FPR / HVLA IND / INR / LAS / ME / MFR / ST / VIS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pelvis/Innom.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	ART / BLT / CR / CS / DIR / FPR / HVLA IND / INR / LAS / ME / MFR / ST / VIS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Abd./Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	ART / BLT / CR / CS / DIR / FPR / HVLA IND / INR / LAS / ME / MFR / ST / VIS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3 Extremity upper	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	ART / BLT / CR / CS / DIR / FPR / HVLA IND / INR / LAS / ME / MFR / ST / VIS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4 Extremity lower	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	ART / BLT / CR / CS / DIR / FPR / HVLA IND / INR / LAS / ME / MFR / ST / VIS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5 Extremity upper	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	ART / BLT / CR / CS / DIR / FPR / HVLA IND / INR / LAS / ME / MFR / ST / VIS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6 Extremity lower	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	ART / BLT / CR / CS / DIR / FPR / HVLA IND / INR / LAS / ME / MFR / ST / VIS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Physician's evaluation of patient prior to treatment: First Visit  Resolved  Improved  Unchanged  Worse

Signature of the examiner \_\_\_\_\_