

# Musculoskeletal Assessment

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Age: \_\_\_\_\_ Gender: \_\_\_\_\_

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## History

*Review of history related to musculoskeletal system:*

YES/NO

If YES, provide details:

### Musculoskeletal

- |                          |                          |                               |       |
|--------------------------|--------------------------|-------------------------------|-------|
| <input type="checkbox"/> | <input type="checkbox"/> | Musculoskeletal disease       | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Recent injury                 | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Exercise history              | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Muscle aches or pain          | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Skeletal aches or pain        | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Muscle weakness or limitation | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Joint pain or stiffness       | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Muscular disease/disorder     | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Neck pain/problem             | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Back pain/problem             | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Shoulder pain/problem         | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Elbow pain/problem            | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Hand or wrist pain/problem    | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Hip pain/problem              | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Knee pain/problem             | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Ankle pain/problem            | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Foot pain/problem             | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Fracture history              | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Change in gait or mobility    | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Musculoskeletal surgery       | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Dietary Ca, protein           | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Chronic disease               | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Bone density evaluation       | _____ |

**Current medications:** \_\_\_\_\_  
\_\_\_\_\_

**Allergies:** \_\_\_\_\_  
\_\_\_\_\_

**Family history/musculoskeletal system:** \_\_\_\_\_  
\_\_\_\_\_

***Review of history related to the current visit:***

**Focused symptom analysis of current problem:**

**Reason for visit:** \_\_\_\_\_  
\_\_\_\_\_

**Character:** \_\_\_\_\_

**Onset:** \_\_\_\_\_

**Duration:** \_\_\_\_\_

**Location:** \_\_\_\_\_

**Severity:** \_\_\_\_\_

**Associated problems:** \_\_\_\_\_

**Efforts to treat:** \_\_\_\_\_

**Physical Assessment**

***Inspection***

**General survey** (posture, body symmetry, gait, deformities, skeletal development, muscle development): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

***Inspection/Palpation***

**Spine** (cervical, thoracic, lumbar, sacral curvatures; tenderness; redness; swelling; deformities): \_\_\_\_\_  
\_\_\_\_\_

**Active and passive ROM** (flexion, extension, rotation, lateral bending; pain limitation): \_\_\_\_\_

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**Shoulders, elbows** (contour, deformity, tenderness, redness, swelling, crepitus): \_\_\_\_\_

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**Shoulders, active and passive ROM** (shoulder internal/external rotation, flexion, extension, pain, limitation): \_\_\_\_\_

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**Elbow** (flexion, extension, pronation, supination, pain limitation): \_\_\_\_\_

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**Wrists, fingers** (size, shape, symmetry, contour, redness, swelling, deformity, tenderness, crepitus): \_\_\_\_\_

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**Forearm, active and passive ROM** (flexion, extension, hyperextension, circumduction, radial/ulnar deviation; pain limitation): \_\_\_\_\_

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**Hips and knees** (contour, size, symmetry, redness, swelling, deformity, tenderness, crepitus): \_\_\_\_\_

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**Hips, active and passive ROM** (internal/external rotation, flexion, extension; pain, limitation): \_\_\_\_\_

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**Knees** (flexion, extension, hyperextension; pain, limitation): \_\_\_\_\_

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**Ballottement:** \_\_\_\_\_

**Ankles, toes** (size, shape, symmetry, deformities, redness, tenderness, swelling): \_\_\_\_\_  
\_\_\_\_\_

**Ankles and feet, active and passive ROM** (flexion, extension, hyperextension, inversion, eversion; pain, limitation): \_\_\_\_\_  
\_\_\_\_\_

***Muscle Strength***

**Muscle strength evaluation** (bilateral evaluation and comparison of all muscle groups by testing extension and flexion of the muscle groups against resistance): \_\_\_\_\_  
\_\_\_\_\_

***Functional Assessment***

**Walking distance:** \_\_\_\_\_  
**Climbing stairs:** \_\_\_\_\_  
**Dressing/grooming:** \_\_\_\_\_  
**Rise from chair:** \_\_\_\_\_  
**Rise from bed:** \_\_\_\_\_  
**Toileting / Bathing:** \_\_\_\_\_

**Analysis:**

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