Outpatient Osteopathic
SOAP Note Form

Usage Guide

Note: In order to fulfill documentation guideline requirements, additional information may need to be recorded by the attending physician.

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# Table of Contents

## Section I: Headings and Identifications
- Name .................................................................................................................. 1
- Date ...................................................................................................................... 1
- Sex ....................................................................................................................... 1
- Age ....................................................................................................................... 1
- Vital Signs ......................................................................................................... 1
- Boxes—for Office Use ..................................................................................... 1

## Section II: Subjective
- Chief Complaint (CC) ....................................................................................... 1
- History of Present Illness (HPI) ......................................................................... 1
- Review of Systems (ROS) ................................................................................ 1
- Past, Family, Social History (PFSH) ................................................................. 1
- Meds—current medications ............................................................................. 2
- Level—to justify level of subjective evaluation and management .................. 2

## Section III: Objective
- Objective Recordings ........................................................................................ 2
- Level of General Multisystem Examination—to justify objective evaluation and management level ...................................................... 2

## Section IV: Musculoskeletal Table
- Method used to Examine .................................................................................. 3
- Region(s) Evaluated ........................................................................................... 3
- Severity Rating ................................................................................................... 3
- Somatic Dysfunction and Other Systems ........................................................ 3
- OMT ..................................................................................................................... 3
- Treatment Method(s) ......................................................................................... 3
- Response—immediately after OMT ................................................................. 4
- Physician Evaluation of Patient Prior to Treatment ....................................... 4

## Section V: Assessment ....................................................................................... 4

## Section VI: Plan
- Number of Areas Treated with OMT ............................................................... 4
- Meds Prescribed ................................................................................................. 5
- Exercise, Nutrition, Physical Therapy (PT), Other ........................................ 5
- Medical Decisions—to justify plan of evaluation and management .......... 5
- Minutes of Patient Contact ............................................................................. 5
- Follow-up—number and units ........................................................................ 5
- Examiner's Signature ....................................................................................... 5

## Example of Completed Outpatient Osteopathic SOAP Note Form .......... 6

## Outpatient Osteopathic SOAP Form ............................................................... 7
Outpatient Osteopathic SOAP Note Form

Section I

Patient's Name: ____________________________  Sex: [ ] Male  [ ] Female  For office use only
Date: ____________________________  Age: ____________________________

Vital Signs: B/P _______  Pulse _______  Respir. _______  Temp. _______  Wt. _______  Ht. _______

Section II

HPI: ____________________________

ROS/PFSH: ____________________________

Meds: ____________________________

Section III

Methods Used to Examine  T=____ A=____ R=____ passive=____ active=____

Severity Scale: [ ] No SD or background (BG) levels  [ ] Obvious TART (esp. R and T), + symptoms
[ ] More than BG levels, minor TART [ ] Key lesions, symptomatic, R and T stand out

Region Evaluated  Severity  Somatic Dysfunctions and Other Systems  OMT  Treatment Method  Response

<table>
<thead>
<tr>
<th>Region Evaluated</th>
<th>Severity</th>
<th>Somatic Dysfunctions and Other Systems</th>
<th>OMT</th>
<th>Treatment Method</th>
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<td>Ribs</td>
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<td>ART / BLT / CR / CS / DIR / FPR / HYLA</td>
</tr>
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</table>

Section IV

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

Section V

OMT performed as above:  1-2 areas  [ ]  3-4 areas  [ ]  5-6 areas  [ ]  7-8 areas  [ ]  9-10 areas  [ ]
Meds: ____________________________

Exercise: ____________________________

Nutrition: ____________________________

Minutes spent with patient:  10  [ ]  15  [ ]  20  [ ]  25  [ ]  30  [ ]  40  [ ]  50  [ ]  60  [ ]  >60  [ ]
Follow-up:  1  [ ]  2  [ ]  3  [ ]  4  [ ]  5  [ ]  6  [ ]  8  [ ]  12  [ ]
Units: ____________________________

Signature of the examiner: ____________________________

03MX2M.PCX  SSWAK  5/98

Funded under a grant from the AOA Bureau of Research @American Academy of Osteopathy
Outpatient Osteopathic SOAP Note Form
Usage Guide

Introduction:

The following Outpatient Osteopathic SOAP Note Form was developed and tested by the American Academy of Osteopathy's Louisa Burns Osteopathic Research Committee under a grant from the American Osteopathic Association. This valid, standardized and easy to use form is our best recommendation to the Osteopathic Profession for research and training in osteopathic medicine.

Instructions for use:

Print where stated. All printing or writing must be legible to anyone, otherwise the record is useless. Blacken the appropriate rectangles. All boxed areas are critical to research data and should be filled in. Data will be collected and analyzed by a computer. Additions to the form can be made. If data was not obtained for a certain section, leave it blank. All definitions were obtained from the CPT book and the Glossary of Osteopathic Terminology. The headings are presented and arranged as they appear on the form, beginning with the upper left-handed corner and reading to the right and down.

Section I: Headings and Identifications

Patient's
Name: Write in the patient's first and last name.
Date: Write in the date of the patient's visit.
Sex: Fill in the box after Male or Female with regards to the patient's gender.
Age: Write in the patient's age in years.

The boxes marked “Office of:” and “For office use only:” can be used for research studies, office record keeping or anyway you'd like.

Vital Signs: Write in the corresponding vital signs on the lines provided labeled B/P (blood pressure), Pulse, Respir. (respirations), Temp (temperature), Wt (weight) and Ht (height). An R (regular) or an I (irregular) can be placed after the number for pulse if known. If a measurement was not taken, leave the space blank.

Section II: Subjective

S: for the SUBJECTIVE part of the SOAP note.

CC: Stands for CHIEF COMPLAINT which is a concise statement describing the symptom, problem, condition, diagnosis or other factor that is the reason for the encounter, usually stated in the patient's words.

HPI: Stands for HISTORY OF PRESENT ILLNESS which is a chronological description of the development of the patient's present illness from the first sign and/or symptom to the present. This includes a description of location, quality, severity, timing, context, modifying factors, and associated signs and symptoms significantly related to the presenting problem(s).

ROS: Stands for REVIEW OF SYSTEMS which is an inventory of body systems obtained through a series of questions seeking to identify signs and/or symptoms which the patient may be experiencing or has experienced which are pertinent to the chief complaint. For the purposes of CPT the following elements of a system review have been identified: Constitutional symptoms, Eyes, Ears/Nose/Mouth/Throat, Cardiovascular, Respiratory, Gastrointestinal, Genitourinary, Musculoskeletal, Integumentary, Neurological, Psychiatric, Endocrine, Hematologic/Lymphatic, Allergic/Immunologic. The review of systems helps define the problem, clarify the differential diagnoses, identify needed testing, or serves as baseline data on other systems that might be affected by any possible management options.

PFISH: Stands for PAST, FAMILY, SOCIAL HISTORY. The PAST HISTORY is a review
of the patient’s past experiences with illnesses, injuries, and treatments that includes significant information about: prior major illnesses and injuries; prior operations; prior hospitalizations; allergies; age appropriate immunization status and age appropriate feeding/dietary status. The FAMILY HISTORY is a review of medical events in the patient’s family that include significant information about: the health status or cause of death of parents, siblings, and children; specific diseases related to problems identified in the Chief Complaint or History of the Present Illness, and/or System Review; diseases of family members which may be hereditary or place the patient at risk. The SOCIAL HISTORY is an age appropriate review of past and current activities that includes significant information about: marital status and/or living arrangements; current employment; occupational history; use of drugs, alcohol, and tobacco; level of education; sexual history; other relevant social factors.

MEDS: Write in the current MEDICATIONS, dosage, route and frequency of administration.

LEVEL: This is a guide for criteria needed to be used to justify your evaluation and management CPT code in the subjective section. Circle the level that applies.

2 1-3HPI: This stands for a level two visit requiring one to three History of Present Illnesses. This is also known as Problem Focused.

3 1-3HPI, 1ROS: This stands for a level three visit requiring one to three History of Present Illnesses and one Review of System. This is also known as Expanded Problem Focused.

4 4+HPI, 2-9ROS, 1PFSH: This stands for a level four visit requiring four or more History of Present Illnesses, two to nine Review of Systems and one component of Past, Family or Social History. This is also known as Detailed.

5 4+HPI, 10+ROS, 2+PFSH: This stands for a level five visit requiring four or more History of Present Illnesses, ten or more Review of Systems and two or more of Past, Family or Social History. This is also known as Comprehensive.

Section III: Objective

0: for the OBJECTIVE section of the SOAP note. Put your physical exam findings for areas/systems in this section. Gait and station as well as inspection and/or palpation of digits and nails for the GMS musculoskeletal exam can be put into this section to fulfill all elements of the exam that aren’t included in the somatic dysfunction table. Overflow data from the musculoskeletal exam can also be put here.

LEVEL GMS: This is a guide for criteria needed to be used to justify your evaluation and management CPT code in the objective section for the GENERAL MULTI-SYSTEM EXAMINATION (GMS). The following body parts and organ systems are recognized: Constitutional, Eyes, Ears/Nose/Mouth/Throat, Neck, Respiratory, Cardiovascular, Chest(Breasts), Gastrointestinal(Abdomen), Genitourinary, Lymphatic, Musculoskeletal, Skin, Neurologic, Psychiatric. See the CPT book for definitions of elements and bullets. Circle the level that applies.

2 1-5 Bulleted elements: For a level two visit you must have examined one to five elements identified by a bullet. This is also known as Problem Focused.

3 6+ Bulleted elements: For a level three visit you must have examined at least six elements identified by a bullet. This is also known as Expanded Problem Focused.

4 2+ Bulleted elements from each of 6 areas OR 12+ elements in 2+ areas: For a level four visit you must have done an examination of at least two elements identified by a bullet from each of six areas/systems OR at least twelve elements identified by a bullet in two or more areas/systems. This is also known as Detailed.

5 2+ Bulleted elements from each of 9 areas: For a level five visit you must perform all elements identified by a bullet in at least nine organ systems or body areas and document at least two elements identified by a bullet from each of nine areas/systems. This is also known as Comprehensive.
Be advised for the musculoskeletal section of the General Multi-system Exam the six areas are: 1) head and neck; 2) spine, ribs and pelvis; 3) right upper extremity; 4) left upper extremity; 5) right lower extremity; 6) left lower extremity.

Warning: To fulfill the elements for anyone of the above areas, in addition to indicating TART findings you must also include an examination of gait and station and inspection and/or palpation of digits and nails.

Section IV: Musculoskeletal Table

METHODS USED TO EXAMINE: Be sure to blacken in the rectangles indicating the tools you used for your examination (T, A, R, T). Included in the definition of these components is the criteria required for coding in each body area.

T: TISSUE TEXTURE CHANGE, stability, laxity, effusions, tone
A: ASYMMETRY, misalignment, crepitation, defects, masses
R: RANGE OF MOTION, contracture
T: TENDERNESS, pain

Filling in these rectangles is a shortcut to a full narrative documentation in the Somatic Dysfunction section.

REGION EVALUATED: This is a list of musculoskeletal body regions arranged in order based on the ICD-9 diagnoses. They include: Head; Cervical; Thoracic; Lumbar; Sacral; Pelvis; Lower Extremities; Upper Extremities; Rib Cage; Abdomen and other (viscera falls into this category). The thoracic region is broken down into three parts based on vertebral levels for specificity: T1-4, T5-9 and T10-12. This was done for ease in listing interrelationships between systems.

SEVERITY: This section refers to the severity (None (0), mild (1), moderate (2), severe (3)) of the most effected somatic dysfunction in a region. Fill in one box for each region examined. For regions that are not examined leave the box empty. If a rectangle is not marked in a region it is assumed that that region was not examined. For regions that are examined the scale is as follows:

0 None ..........No somatic dysfunction present or background (BG) level.
1 Mild ..........More than background, minor TART elements.
2 Moderate...Obvious TART elements, may or may not be overly symptomatic but significant R and/or T.
3 Severe ......KEY LESIONS, significant symptomatic, stands out; R and/or T elements stand out with minimum search or provocation.

(In the center of the table is a quick reference for the severity scale.)

SOMATIC DYSFUNCTION & OTHER SYSTEMS: Somatic Dysfunction is defined as impaired or altered function of related components of the somatic (body framework) system: skeletal, arthrodial, and myofascial structure, and related vascular, lymphatic, and neural elements. In this section for each region assessed, write your somatic dysfunctions including musculoskeletal (MS); sympathetic nervous system (SNS); parasympathetic nervous system (PSNS); lymphatic (LYM); cardiovascular (CV); respiratory (RESP); gastrointestinal (GI); fascial (FAS); etc. components. Use standard terminology. If you filled in boxes under TART you do not need to write anything here for coding purposes but it is a good section to put in your notes for personal use.

OMT: If boxes 0, 1, 2, or 3 are filled in under severity then there must be a mark in the OMT section for that same region. Fill in the YES box if Osteopathic Manipulative Treatment (OMT) was performed or the NO box if no OMT was performed for each region examined.

TREATMENT METHOD: Listed here are the abbreviations approved by the profession for the treatment modalities used to treat the somatic dysfunctions listed previously. Circle the modalities used in each region treated.

ART: articulatory treatment
BLT: balanced ligamentous tension treatment/ligamentous articular strain treatment
CR: cranial treatment/osteopathy in the cranial field/cranial osteopathy
CS: counterstrain treatment
DIR: direct treatment
FPR: facilitated positional release treatment
HVLA: high velocity/low amplitude treatment
IND: indirect treatment
INR: integrated neuromuscular release
LAS: ligamentous articular strain treatment/balanced ligamentous tension treatment
ME: muscle energy treatment
MFR: myofascial release treatment
ST: soft tissue treatment
VIS: visceral manipulative treatment

RESPONSE: Fill in one box for each region of somatic dysfunction that was treated with OMT. This is the physicians perception of how the somatic dysfunctions in each region responded to Osteopathic Treatment immediately after treatment. The boxes are indicated as follows:

R: The somatic dysfunction is completely RESOLVED without evidence of it having ever been present.
I: The somatic dysfunction is IMPROVED but not completely resolved.
U: The somatic dysfunction is UNCHANGED or the same after treatment as it was before treatment.
W: The somatic dysfunction is WORSE or aggravated after treatment.

PHYSICIAN'S EVALUATION OF PATIENT PRIOR TO TREATMENT: This is the physician's overall opinion of how well the patient is doing based on his or her objective findings of the patient prior to treatment compared to the last visit.

FIRST VISIT: If this is the patients first visit for a particular problem, mark the rectangle after first visit.
RESOLVED: The problems for which the patient is following up on are resolved. This implies that if a patient presents for a follow up on a musculoskeletal problem, there are no findings in the table under the somatic dysfunction section. However, the region assessed could be checked with zero severity indicating that no somatic dysfunction was found.

IMPROVED: The problems for which the patient is following up on are improved but not totally resolved.
UNCHANGED: The problems for which the patient is following up on are no different or completely unchanged from the way they were at the prior visit. This implies that for musculoskeletal problems the general severity of the overall somatic findings in a patient are similar to what they were at the last visit even if they are not exactly the same. This may also happen if you evaluate or consult on a patient at one visit but do not institute any treatment at that visit.
WORSE: The problems for which the patient is following up on are worse then they were at the last visit. This could occur with a musculoskeletal problem if no treatment was started at the last visit, the patient did something to aggravate their condition or the patient had a complication or side effect of treatment given at the last visit. This refers to how the patient is at the current visit. This does not reflect how their early delayed response, i.e. "flare up", from the last treatment was. Flare up information can be charted in the subjective section of the note.

Section V: Assessment

A: for the ASSESSED section of the SOAP note.

1-4 spaces are available fro ICD-9 diagnoses to be listed in the order of their importance.

Section VI: Plan

P: for the Plan Section of the SOAP form.

OMT PERFORMED AS ABOVE: Fill in the box for the number of regions of somatic dysfunction that were treated. This number should correlate with the number of YES boxes in the OMT section of the table and the number of boxes in the severity section of the table marked one, two, or three. Beware that although the Thoracic region is divided into three sections on the table it only counts as one region for CPT coding. The boxes are as follows:
1-2 areas: You treated one to two regions of somatic dysfunction with Osteopathic Manipulative Treatment.

3-4 areas: You treated three to four regions of somatic dysfunction with Osteopathic Manipulative Treatment.

5-6 areas: You treated five to six regions of somatic dysfunction with Osteopathic Manipulative Treatment.

7-8 areas: You treated seven to eight regions of somatic dysfunction with Osteopathic Manipulative Treatment.

9-10 areas: You treated nine to ten regions of somatic dysfunction with Osteopathic Manipulative Treatment.

MEDICAL DECISIONS: This is a guide for criteria needed to be used to justify your evaluation and management CPT code in the Plan section. It is based on the number of options, complexity of records and risk of significant complications. Circle the level that applies.

2 Minimal Decisions: This stands for a level two visit requiring minimal decision making.

3 Limited Decisions: This stands for a level three visit requiring limited decision making.

4 Moderate Decisions: This stands for a level four visit requiring moderate decision making.

5 Extensive Decisions: This stands for a level five visit requiring extensive decision making.

MINUTES SPENT WITH PATIENT: Fill in the box that corresponds to the amount of time you spent face-to-face with the patient and/or family during their visit: 10, 15, 25, 40, 60 or >60 minutes. These correspond to the time allotments in the CPT book. Choose the one that best fits.

FOLLOW-UP AND UNITS: Fill in the boxes that correspond to when you would like to see the patient again both in number and units. For example for one month fill in the box above 1 and the box above Mo.(month). Other abbreviations are as follows: Days, Wk.(week), Yr.(year) and PRN(as needed).

SIGNATURE of the examiner: Write your signature in this space.
**Outpatient Osteopathic SOAP Note Form**

**Patient's Name:** Same Doe  
**Sex:** Male  
**Date:** 11/19/23  
**Age:** 25  
**Vital Signs:** B/P 120/80  
Pulse 80  
Respir. 20  
Temp. 98.6  
Wt. 130 Ht. 5'5"

**S (Subjective):** Stomachache, back pain  
**P (Pertinent):** Started 2 days ago, hurts mostly mid epigastrum  
T and back  
Radiation, eating, bed rest help  
**O (Objective):** No trauma, had no decubitus ulcers.  
**Tenderness epigastrum, bowel sounds, masses.**  
**UE Litmus muscle strength 5/5**

**Level of OMT:**  
2 = 1-5 elements  
4 = 2+ elements from each of 9 areas  
**Method Used to Examine**  
1 = active  
2 = passive  
3 = T

<table>
<thead>
<tr>
<th>Region Evaluated</th>
<th>Severity</th>
<th>Somatic Dysfunctions and Other Systems</th>
<th>OMT</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Head</td>
<td>0 1 2 3</td>
<td>Varicose and tender touch</td>
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</tr>
<tr>
<td>Neck</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td>Thoracic T1-4</td>
<td>0 1 2 3</td>
<td>T1-L T8-L</td>
<td>ART / BLT / CR / CS / FPR / HVLA</td>
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</tr>
<tr>
<td>T5-9</td>
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<td>T1-L (FL)</td>
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<tr>
<td>T10-12</td>
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<td>Lumbar</td>
<td>0 1 2 3</td>
<td>Sciatic Neural strain</td>
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<td></td>
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<td>0 1 2 3</td>
<td>WNL</td>
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<td>Abductor tendinous T1-L</td>
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<tr>
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<td>R 0 1 2</td>
<td>Abduction 160</td>
<td>ART / BLT / CR / CS / FPR / HVLA</td>
<td></td>
</tr>
<tr>
<td>Ribs</td>
<td>0 1 2 3</td>
<td>Mobility stomach</td>
<td>ART / BLT / CR / CS / FPR / HVLA</td>
<td></td>
</tr>
</tbody>
</table>

**Treatment Method**  
(Circle Treatment Methods Used)

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

1. Gastritis  
2. Thoracic Strain  
3.  
4.  

**OMT performed as above:**  
1-2 areas  
3-4 areas  
5-6 areas  
7-8 areas  
9-10 areas  

**Meds:**  
NAD Proserc 20mg daily  
PT: Hot rocks done  

**Medical Decisions:**  
2 = minimal decisions  
3 = limited decisions  
4 = moderate decisions  
5 = excessive decisions  

**Exercise:** Shoulder stretch  
**Nutrition:** bland diet  

**Minutes spent with patient:**  
10 15 20 25 30 40 60 90  

**Follow-up:**  
1 2 3 4 5 6 7 8 9 10 11 12  

**Signature of the examiner:**

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### Outpatient Osteopathic SOAP Note Form

**Patient's Name:** ___________________________  **Sex:** □ Male  □ Female  **For office use only:**

**Date:** ___________________________  **Age:** __________

**Vital Signs:** B/P _______  **Pulse** _______  **Respir.** _______  **Temp.** _______  **Wt.** _______  **Ht.** _______

**S:**

- **CC:** 
- **HPI:** 
- **ROS/PFSH:** 
- **Meds:** ___________________________

### Methods Used to Examine

<table>
<thead>
<tr>
<th>Region Evaluated</th>
<th>Severity</th>
<th>Somatic Dysfunctions and Other Systems</th>
<th>OMT</th>
<th>Treatment Method</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>MS / SNS / PNS / LYM / CV / RESP / GI / FAS / etc.</td>
<td>Yes / No</td>
<td>(Circle Treatment Methods Used)</td>
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<tr>
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<td>R I U W</td>
</tr>
<tr>
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<td>O 1 2 3</td>
<td>[ART / BLT / CR / CS / DIR / FPR / HVLA IND / INR / LAS / ME / MPR / ST / VIS]</td>
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<td>Lumbar</td>
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<td>[ART / BLT / CR / CS / DIR / FPR / HVLA IND / INR / LAS / ME / MPR / ST / VIS]</td>
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<td>Sacrum/Pelvis</td>
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<tr>
<td>Extremity lower</td>
<td>R</td>
<td>[ART / BLT / CR / CS / DIR / FPR / HVLA IND / INR / LAS / ME / MPR / ST / VIS]</td>
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<tr>
<td>Extremity upper</td>
<td>R</td>
<td>[ART / BLT / CR / CS / DIR / FPR / HVLA IND / INR / LAS / ME / MPR / ST / VIS]</td>
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<tr>
<td>Ribs</td>
<td></td>
<td>[ART / BLT / CR / CS / DIR / FPR / HVLA IND / INR / LAS / ME / MPR / ST / VIS]</td>
<td></td>
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<tr>
<td>Abd./Other</td>
<td></td>
<td>[ART / BLT / CR / CS / DIR / FPR / HVLA IND / INR / LAS / ME / MPR / ST / VIS]</td>
<td></td>
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</tbody>
</table>

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

1. ___________________________________________  3. ___________________________________________
2. ___________________________________________  4. ___________________________________________

**OMT performed as above:** 1-2 areas □  3-4 areas □  5-6 areas □  7-8 areas □  9-10 areas □

**Meds:** ______________________________________  **PT:** ___________________________

**Exercise:** ___________________________  **Other:** ___________________________

**Nutrition:** ___________________________

**Minutes spent with patient:** 10 15 25 40 60 >60  **Follow-up:** 1 2 3 4 5 6 8 11 12  **Units:** Days Wk Mo Yr FRN

Signature of the examiner: ___________________________

Funded under a grant from the AOA Bureau of Research ©American Academy of Osteopathy