Outpatient Osteopathic Single Organ System Musculoskeletal Form Series

Usage Guide

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Blank Forms

Outpatient Health Summary

wak SOS version 5:091102b

Patient's Name		**Date**	**Update:**
Date of Birth	**Sex**	**Phone Number**	**Home**
Marital Status: M S D W			
Significant Others:		**DNR**	**No** **Qualifications:**
		Resuscitate:	
Religion:		**Next of Kin:**	

Section I page 5

Social History:	**Employment**	**Occupation**	**Education**	
	Tobacco	**ETOH**	**Drugs**	**Sex Hx**
Family History:	**M**	**Siblings**	**Others:**	
	F			

Section II page 5-6

Past Medical History

CPT#	Start Date	Problem / Diagnosis	Medications	Start	Stop

Section III page 6

Allergies, Adverse Drug Reactions:

Health Maintenance

Parameter	Dates							
DPT/DT/TD								
OPV								
MMR								
HIB								
Influenza								
Hepatitis								
PPD/Tine								
Pneumovax								
H & P								
Eye exam								
Dental exam								
PAP smear								
Mammogram								
Urinalysis								
Hemoccult								
Cholesterol								
Sigmoidoscopy								
Others								

Section IV page 6

Past Surgical History

Date	Type

Section V page 6

Consultants

Section VI page 6

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Designed to coordinate with the Established Outpatient Osteopathic SOAP Note Form. Recommended by American Association of Colleges of Osteopathic Medicine.

Outpatient Osteopathic SOS History / Exam Form

wak SOS version 5:091102b

Office of:

For office use only:

Patient's Name _____ **Date**_____

HISTORY

S (See Outpatient Health Summary Form for details of history)

Patient's Pain Analog Scale: ☐ Not done

NO PAIN — WORST POSSIBLE PAIN

Section I page 7

CC

History of Present Illness **Level: HPI**

Elements		
☐	Location	
☐	Quality	
☐	Severity	
☐	Duration	
☐	Timing	
☐	Context	
☐	Modifying factors	
☐	Assoc. Signs and Sx	

OR Status of ≥ 3 chronic or inactive conditions

_____

_____

_____

☐	**II** / **III**	1-3 elements reviewed
☐	**IV** / **V**	≥ 4 elements OR status of ≥ 3 chronic conditions

Review of Systems (Only ask / record those systems pertinent for this encounter.) ☐ Not done **Level: ROS**

☐	Constitutional (Wt loss, etc.)
☐	Eyes
☐	Ears, nose, mouth, throat
☐	Cardiovascular
☐	Respiratory
☐	Gastrointestinal
☐	Genitourinary
☐	Musculoskeletal
☐	Integumentary (skin, breast)
☐	Neurological
☐	Psychiatric
☐	Endocrine
☐	Hematologic/lymphatic
☐	Allergic/immunologic

Section II page 7-8

☐	**II**	None
☐	**III**	1 system pertinent to the problem
☐	**IV**	2-9 systems
☐	**V**	≥ 10 systems

Past Medical, Family, Social History ☐ Not done **Level: PFSH**

☐	Past history / trauma
☐	Family history
☐	Social history

☐	**II** / **III**	None
☐	**IV**	1 history area
☐	**V**	≥ 2 history areas

Overall History = Average of HPI, ROS or PFSH: ☐ **II** (1-3 HPI) ☐ **III** (1-3 HPI, 1 ROS) ☐ **IV** (4+ HPI, 2-9 ROS, 1 PFSH) ☐ **V** (4+ HPI, 10+ ROS, 2+ PFSH)

O

Section III page 8

Signature of transcriber: _____ Signature of examiner: _____

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Outpatient Osteopathic SOS Musculoskeletal Exam Form

wak SOS version 5:091102b

O ☐ Not done

Office of:

Patient's Name _____ **Date** _____ Female ☐

Age ____ * Vital Signs (3 of 7) Wt. _____ Temp. _____

For office: use only

Reg. ☐ Pt. position for recording BP:

Resp. ____ Pulse ____ Irreg. ☐ Standing_____ Sitting_____ Lying_____

Section I page 8-9

* **Gait and Station:**

Body Type: Endo. ☐ Meso. ☐ Ecto. ☐

Posture: Excl. ☐ Fair ☐ Poor ☐

Gait: Symmetrical ☐ Asymmetrical ☐

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

Cervical Lordosis ☐ ☐ ☐

Thoracic Ky ☐ ☐ ☐

Lumbar Lor ☐ ☐ ☐

I = increased; N = normal; D = decreased

Section II page 9

Scoliosis (Lateral Spinal Curves):

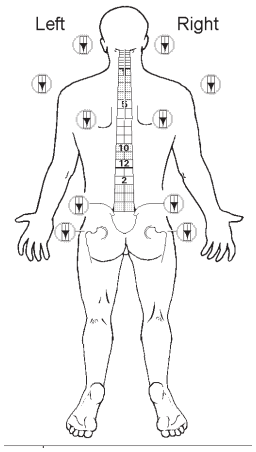
None ☐ Sitting ☐

Functional ☐ Standing ☐

Mild ☐ Prone/Supine ☐

Moderate ☐ Unable to Examine ☐

Severe ☐



Horizontal Planes

Notes

* Gen. Appearance: **Y** **N**

Normal ☐ ☐

***Cardiovascular** ☐ ☐

Observation normal ☐ ☐

Palpation normal ☐ ☐

***Lymphatics**

No palpable nodes ☐ ☐

Section III page 9-10

c:

☐ ☐

Sensory intact ☐ ☐

Mental status

Oriented:

In time ☐ ☐

In person ☐ ☐

In place ☐ ☐

Good mood/ affect ☐ ☐

Short leg? Right: 1/8 ☐ ¼ ☐ ½ ☐

Equal ☐ Left: 1/8 ☐ ¼ ☐ ½ ☐

Level of SOS

☐ **II** 1-5 elements

☐ **III** 6+ elements

* **Skin:** **N** **Ab** **N** **Ab** **N** **Ab**

Head / neck ☐ ☐ L. upper extremity ☐ ☐ L. lower extremity ☐ ☐

Trunk ☐ ☐ R. upper extremity ☐ ☐ R. lower extremity ☐ ☐

☐ **IV** 12 + elements for musculoskeletal exam

☐ **V** Perform all * elements

Section IV page 10-11

* **Reflexes:** **0** **1** **2** **3** **4**

Biceps L ☐ ☐ ☐ ☐ ☐

R ☐ ☐ ☐ ☐ ☐

Triceps L ☐ ☐ ☐ ☐ ☐

R ☐ ☐ ☐ ☐ ☐

Brachio- L ☐ ☐ ☐ ☐ ☐

Radialis R ☐ ☐ ☐ ☐ ☐

Patella L ☐ ☐ ☐ ☐ ☐

R ☐ ☐ ☐ ☐ ☐

Achilles L ☐ ☐ ☐ ☐ ☐

R ☐ ☐ ☐ ☐ ☐

Babinski L up ☐ down ☐

R up ☐ down ☐

		1	**2**	**3**	**4**	**5**			**1**	**2**	**3**	**4**	**5**
C5	L	☐	☐	☐	☐	☐	T1	L	☐	☐	☐	☐	☐
	R	☐	☐	☐	☐	☐		R	☐	☐	☐	☐	☐
C6	L	☐	☐	☐	☐	☐	L4	L	☐	☐	☐	☐	☐
	R	☐	☐	☐	☐	☐		R	☐	☐	☐	☐	☐
C7	L	☐	☐	☐	☐	☐	L5	L	☐	☐	☐	☐	☐
	R	☐	☐	☐	☐	☐		R	☐	☐	☐	☐	☐
C8	L	☐	☐	☐	☐	☐	S1	L	☐	☐	☐	☐	☐
	R	☐	☐	☐	☐	☐		R	☐	☐	☐	☐	☐

Methods Used For Examination

Key to the Severity Scale

0 = No SD or background (BG) levels

1 = More than BG levels, minor TART

2 = Obvious TART (esp. R and T), +/- symptoms

3 = Key lesions, symptomatic, R and T stand out

Section V page 11

	All	**T**	**A**	**R**	**T**	**Region Evaluated**	**Severity 0**	**1**	**2**	**3**	**Somatic Dysfunction and Other Systems** MS / SNS / PNS / LYM. / CV / RESP. / GI / FAS. / etc.
*1	☐	☐	☐	☐	☐	Head and Face	☐	☐	☐	☐	
	☐	☐	☐	☐	☐	Neck	☐	☐	☐	☐	
*2	☐	☐	☐	☐	☐	Thoracic T1-4	☐	☐	☐	☐	
	☐	☐	☐	☐	☐	T5-9	☐	☐	☐	☐	
	☐	☐	☐	☐	☐	T10-12	☐	☐	☐	☐	
	☐	☐	☐	☐	☐	Ribs	☐	☐	☐	☐	
	☐	☐	☐	☐	☐	Lumbar	☐	☐	☐	☐	
	☐	☐	☐	☐	☐	Sacrum / Pelvis	☐	☐	☐	☐	
	☐	☐	☐	☐	☐	Pelvis / Innom.	☐	☐	☐	☐	
	☐	☐	☐	☐	☐	Abd ./ Other	☐	☐	☐	☐	
*3	☐	☐	☐	☐	☐	Upper R	☐	☐	☐	☐	
*4	☐	☐	☐	☐	☐	Extremity L	☐	☐	☐	☐	
*5	☐	☐	☐	☐	☐	Lower R	☐	☐	☐	☐	
*6	☐	☐	☐	☐	☐	Extremity L	☐	☐	☐	☐	

Signature of transcriber: _____

Signature of examiner: _____

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Outpatient Osteopathic Initial Assessment and Plan Form

wak SOS version 5:091102b

A Patient's Name_____ D____

Section I page 12

Office of:
For office use only:

Dx No.	ICD Code	Written Diagnosis	Dx No.	ICD Code	Written Diagnosis
	739.0	Somatic Dysfunction of Head and Face		739.4	Somatic Dysfunction of Sacrum
	739.1	Somatic Dysfunction of Neck		739.5	Somatic Dysfunction of Pelvis
	739.2	Somatic Dysfunction of Thoracic		739.9	Somatic Dysfunction of Abd / Other
	739.8	Somatic Dysfunction of Ribs		739.7	Somatic Dysfunction of Upper Extremity
	739.3	Somatic Dysfunction of Lumbar		739.6	Somatic Dysfunction of Lower Extremity

Section II page 12

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

P

Section III page 12-13

☐ All not done **Region**	OMT		Treatment Method															Response			
	Y	N	ART	BLT	CR	CS	DIR	FPR	HVLA	IND	INR	LAS	ME	MFR	ST	VIS	OTH	R	I	U	W
Head and Face	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Neck	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Thoracic	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Ribs	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Lumbar	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Sacrum	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Pelvis	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Abdomen/Other	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Upper Extremity	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Lower Extremity	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Meds: PT:

Exercise:

Nutrition:

Section IV page 13

Complexity / Assessment / Plan (Scoring) *Default to level 2—same criteria

Problems		Risk: (Presenting problem(s), diagnostic procedure(s), and management options)	Data	Maximum Points
Self-limiting	1 (2 max.)		Lab	1
Established problem improved / stable	1	Minimal = Min.	Radiology	1
Established—worsening	2	Low	Medicine	1
New—no workup	3 (3 max.)	Moderate = Mod.	Discuss with performing physician	1
New additional workup	4	High	Obtain records or Hx from others	1
			Review records, discuss with physician	2
			Visualization of tracing, specimen	2

Level I	Level II	Level III	Level IV	Level V	Level I	Level II	Level III	Level IV	Level V	Level I	Level II	Level III	Level IV	Level V
*	≤1 pt.	2 pt.	3 pt.	≥4 pt.	*	Min.	Low	Mod.	High	*	≤1 pt.	2 pt.	3 pt.	≥4 pt.
	☐	☐	☐	☐		☐					☐	☐	☐	☐

Requires 3 of above 3 (problems, risk and data). Level of complexity = av

Section V page 14

Traditional Method—Coding by Components

	I	II	III	IV	V
History					
Examination					
Complexity / Assessment Plan					
Final level of service	☐	☐	☐	☐	☐

All three areas required. Average of three equals level of service.

Optional Method—Coding by Time

When majority of the encounter is counseling / coordinating, the level is determined by total time

	I	II	III	IV	V
New patients (minutes)	10	20	30	45	60
Outpatient consults (minutes)		10	15	25	40
Final level of service	☐	☐	☐	☐	☐

Dictate total time and counseling / coordinating time plus a brief description of topics discussed

Minutes spent with the patient: ☐ 10 ☐ 15 ☐ 25 ☐ 40 ☐ 60 ☐ >60 **Follow-up:** ☐ 10 ☐ 11 ☐ 12 **Units:** ☐ D ☐ W ☐ M ☐ Y ☐ PRN

Section VI page 14-15

OMT performed as Above: 0 areas ☐ 1-2 areas ☐ 3-4 areas ☐ 5-6 areas ☐ 7-8 areas ☐ 9-10 areas ☐

Other Procedures Performed:	CPT Codes:																
	Written Dx:																
E/M Code:	**New**	☐	☐	☐	☐	**EST**	☐	☐	☐	☐	☐	**Consults**	☐	☐	☐	☐	☐
Write 992 plus . . .		*02*	*03*	*04*	*05*	*. . .*	*11*	*12*	*13*	*14*	*15*	*. . .*	*41*	*42*	*43*	*44*	*45*

Signature of transcriber: _____ Signature of examiner: _____

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Outpatient Osteopathic Single Organ System Musculoskeletal Form Series Usage Guide

Introduction:

The following Health Summary Sheet and the three-page Outpatient Osteopathic Single Organ System Musculoskeletal Form Series was developed by the American Academy of Osteopathy's Louisa Burns Osteopathic Research Committee. The Outpatient Osteopathic Single Organ System Musculoskeletal Exam Form portion of this series was validated by 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 bold boxed areas are critical to research data and should be filled in. Data can 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 or fill in the "not done" rectangle. 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-hand corner and reading to the right and down. Bold text in this Usage Guide corresponds to Form text.

Initial Page:

OUTPATIENT HEALTH SUMMARY This page of the system is the front left hand page of a two-section chart system or the front page of a one-section chart. At each patient visit it provides rapid ID, recall of wishes for care, who and how to call in case of an emergency, and a quick retrieval of past medical, surgical and medication history, consultants and immunizations. This page is reviewed at each patient visit and all sections kept current.

Section I: Identification and Disposition

Patient's Name: Write in the patient's first and last name.

Date: Write in the date this initial summary was started. Use the following format for all dates: month/day/year.

Update: Write in the dates that this form is updated. Separate dates by commas, with the most recent furthest to the right (month/day/year).

Date of Birth: (month/day/ year).

Sex: Male or **F**emale gender.

Phone Numbers: Provide **Home** phone number and a **Work** phone number if appropriate.

Marital Status: Circle correct letter to indicate if **M**arried, **S**ingle, **D**ivorced, or **W**idowed.

Significant Others: List them and include living arrangements

DNR Status or **Resuscitate** (**Yes, No**) and **Qualifications:** Indicate the patient's or guardian's wishes regarding resuscitation by checking the "**Yes**" or "**No**" box. Additional desires or wishes for terminal care can be added here in **Qualifications** box.

Religion: Write in the patient's religion or preference for last rites.

Next of Kin: Write in the name of whom should be contacted in case of emergency should the patient die, or who is the beneficiary.

Section II: Social and Family History

Social History: is an age appropriate review of past and current activities that includes significant information about:

Employment: Write in the patient's current and past employment, and if appropriate, places of work. Indicate if patient is retired; indicate any risk factors associated with the work place (i.e. black lung, asbestos exposure, fumes, etc.).

Occupation: Write in the patient's areas of training (chemist, teacher, homemaker).

Education: Write in the patient's current school status, degrees obtained or highest grade obtained.

Tobacco: Write in the pack/years, what form (cigarettes, cigars, chewing tobacco) and quit dates if appropriate.

ETOH (alcohol)**:** Write in the patient's alcohol use in number; what consumed (beer, cocktails), how often (daily, weekly, monthly, yearly). Indicate past abuse and sober date.

Drugs: Write in the patients illicit drug use, past and present, what, when and for how long.

Sex Hx (sexual history)**:** Write in the patient's sexual preference, partners, menstrual history; gravida number and para number (The female patient has a gravida number if presently pregnant; otherwise she only has a para number. A para number is a 4-digit number indicating the number of "pregnancies-prematures-abortions-and living children.")

Family History: is a review of medical events in the patient's family that include significant information about: (**M**other, **F**ather) 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.

Use ↑ if the relative (mother, father, sibling, etc.), is living and ↓ if deceased. If deceased, indicate the age of death and cause. List their pertinent health problems or history.

Others: List any pertinent health history or information on other relatives such as maternal grandmother ↓ age 50, breast cancer, etc.

Section III: Past Medical History

Past Medical History is a review of the patient's past experiences with illness, injuries, and treatment that includes significant information about:

CPT #: Write in any CPT codes that might be helpful for easy reference when coding.

Start Date of Problem: Write in the date when a problem began or when a diagnosis was first made (month/day/year).

Problem/Diagnosis: Write in the patient's prior illnesses, injuries**,** and prior hospitalizations in order of occurrence when possible.

Medications: Medications and dosages are listed in order of their initial use. Also list here over-the-counter substances such as herbs, vitamins and homeopathic remedies.

Start Date for Medications: Write in the date that each medication/substance was started and when dosages are/were changed (month/day/year).

Stop Date for Medications: Write in the date that each medication/substance was discontinued (month/day/year). Leave blank if the patient is currently taking a medication.

A**llergies, Adverse Drug Reactions:** List medications, foods, animals, etc. that cause allergic reactions or that produced unexpected results. List the nature of the reaction or result.

Section IV: Health Maintenance

Parameter and **Dates:** This is a running list of dates (month/day/year) of the usual immunizations, exams, tests and procedures. There is also a line for "**Others**" write-ins.

Section V: Past Surgical History

Date and **Type:** Surgical date and type are listed in order of occurrence (month/day/year).

Section VI: Consultants

Consultants: These are listed including the consultant's name and specialty.

PAGE 1 of 3:

OUTPATIENT OSTEOPATHIC SINGLE ORGAN SYSTEM (SOS) HISTORY/EXAM FORM

This page of the system provides the subjective portion of an SOS note for a patient visit. It has supplemental writing space for the objective portion of the chart that is completed on page 2 of 3.

S: the **S**ubjective section of the **S**OAP note.

Section I: Patient Name, Date, Patient's Pain Analog Scale and CC

Patient's Name and Date: The first and last name of the patient and the date of this visit are recorded (month/day/year).

The boxes marked "**Office of**:" and "**For office use only**" can be used for tracking a research study, for office record keeping, etc.

Patient's Pain Analog Scale: The patient is asked to place a mark on the 0-10 analog scale indicating the degree of pain he/she has at the time of this interview. Patients are given the following instructions: "If you have **NO PAIN**, place a mark at the far left side. If this is the **WORST POSSIBLE PAIN** you have ever experienced, indicate it at the far right side. Indicate where your pain is at this time." If the patient doesn't have pain or this information was not obtained, fill in the "**Not done**" rectangle.

CC Stands for **Chief Complaint** which is a concise statement describing the symptoms, problem, condition, diagnosis or other factors that is the reason for the encounter. **CC** usually is stated in the patient's words. Extra lines are included here for other details of the subjective history not included in the rest of this section or those needing more space for details.

Section II: History of Present Illness, Review of Systems and Past Medical, Family and Social History

History of Present Illness (HPI)**:** The HPI 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, duration, timing, context, modifying factors, and associated signs and symptoms significantly related to the presenting problem(s). Fill in all rectangles and write in the details after each element listed for the history elicited. OR, write in the status of 3 or more chronic or inactive conditions on the lines provided.

Level: HPI: This is a guide for criteria needed to justify your evaluation and management CPT code in the subjective section. Fill in the rectangle that applies. The Roman numerals stand for the level of new outpatient visit for which the patient qualifies. A level two (99202) or three (99203) code requires 1-3 of the HPI elements to qualify. A level four (99204) or five (99205) code requires ≥ 4 HPI elements OR the status of ≥ 3 chronic conditions.

Review of Systems (ROS) is an inventory of body systems, pertinent to the chief complaint, that are obtained through a series of questions seeking to identify signs and/or symptoms which the patient may be experiencing or has experienced. ROS is a guide for criteria needed to justify your evaluation and management CPT code in the subjective section. For the purposes of CPT the following systems review have been identified: Constitutional symptoms, Eyes, Ears/Nose/Mouth/Throat, Cardiovascular, Respiratory, Gastrointestinal, Genitourinary, Musculoskeletal, Integumentary, Neurological, Psychiatric, Endocrine, Hematologic/lymphatic, and 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. Only fill in the rectangle(s) of those systems reviewed at this encounter. Write in any details elicited after each system. If you examine a system and it is normal, fill in the rectangle for that system and write Within Normal Limits (WNL) on that line. If no ROS information was obtained, fill in the "**Not done**" rectangle.

Level: ROS: The Roman numerals stand for the level of new outpatient visit for which the patient qualifies. A level two (99202) requires no ROS. Level three (99203) requires one system pertinent to the problem. Level four (99204) requires 2-9 systems. Level five (99205) requires

listing of ≥ 10 systems. Fill in the rectangle that applies.

Past Medical, Family, Social History (PFSH)**:** The **Past history/ trauma** 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, or children; specific diseases related to problems identified in the **C**hief **C**omplaint or History of the Present Illness, and/or System Review; diseases of family that 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.

Fill in the rectangle(s) and write in any extra history not included on the **Outpatient Health Summary Form**, such as trauma history. If no medical, family or social history was obtained on the **Outpatient Health Summary** or the **Outpatient Osteopathic SOS History/Exam Forms,** fill in the "**Not done**" rectangle.

Level: PFSH: The Roman numerals stand for the level of new outpatient visit for which the patient qualifies. A level two (99202) and three (99203) requires no history areas to be present. Level four (99204) requires one history area. Level five (99205) requires 2 or more history areas. Fill in the rectangle that applies.

Overall History: Fill in the rectangle that indicates the average level determined using the level of HPI, ROS or PFSH provided.

Section III: "O" and Signature of Examiner

O: This is part of the **O**bjective section of the **S**OAP Note. This section and is used to write any further objective information that could not be included in page 2 of 3.

Signature of examiner: Signature of the attending physician is mandatory. Also, the transcriber should sign if this is appropriate.

Page 2 of 3:
Outpatient Osteopathic Single Organ System (SOS) Musculoskeletal Exam Form

This page of the system provides space for recording vital signs and any visceral and musculoskeletal examination findings obtained in an SOS musculoskeletal examination.

O: the **O**bjective section for the S**O**AP note continues. (Actually, the Objective section usually is started on this page.) Physical exam findings for the listed areas/systems are recorded here. Most can be documented by blackening the appropriate rectangle after the examination is performed. There is also a table where specific musculoskeletal exam findings can be recorded and documented. If no physical exam was done at this encounter, fill in the "**Not done**" rectangle.

Section I: Patient's Name, Date, Sex, Age and Vital Signs

Patient's Name: Write in the patient's first and last name.

Date: Write in the date of the patient's visit month/day/year).

Sex: Fill in the correct rectangle for **Male** or **Female** gender.

Age: Write in the patient's age in years. If a child use days up to 1 month, months up to 1 year and then years of age.

Vital Signs: Write in the corresponding vital signs on the lines provided. Three (3) of the seven (7) listed are needed to fulfill the requirements for a comprehensive examination. The seven include: 1. **Wt.** (weight in pounds; lbs), 2. **Ht.** (height in feet and inches; ft, in), 3. **Temp.** (temperature in degrees Fahrenheit), 4. **Resp.** (rate of respiration in breaths-per-minute), 5. **Pulse** rate (in beats-per-minute) and whether it is regular (**Reg.**) or irregular (**Irreg.**), 6. **BP** (blood pressure)

Standing, **Sitting**, and 7. BP **Lying** down. If a measurement was not taken, leave the space blank.

The boxes marked "**Office of:**" and "**For office use only:**" can be used to identify research studies, office record keeping, etc.

Section II: Gait and Station, Ant./Post. Spinal Curves, Scoliosis and Horizontal Planes

Gait and Station:

Body type: Fill in the appropriate rectangle, indicating whether the patient's general body build is endomorphic (**Endo** = soft, over-weight and visceral), mesomorphic (**Meso** = solid and muscular) or ectomorphic (**Ecto** = thin, hairy, etc.).

Posture: Fill in the appropriate rectangle describing the patient's posture: Excellent (**Excl.**), **Poor** or somewhere in between (**Fair**).

Gait: If ambulatory, fill in the appropriate rectangle describing the observed gait: **Symmetrical** or **Asymmetrical**.

Ant./Post. Spinal Curves: Observe each spinal region—cervical, thoracic and lumbar—from the lateral position, for increased (**I**), normal (**N**) or decreased/flattened (**D**) AP curvature. Blacken the appropriate rectangle for each region examined.

Scoliosis (Lateral Spinal Curves): Observe each region and the spine as a unit for the presence and severity of lateral curvature. Then blacken the appropriate rectangle. **Functional** indicates a flexible curve that changes with forward bending. Estimate if the scoliosis is **Mild** (5-15^{o}), **Moderate** (20-45^{o}) or **Severe** (>50^{o}). (Optional: You may **also** draw the lateral curvature on the provided **diagram** if you desire.) Blacken in the appropriate rectangle(s) to indicate the positions in which the patient was examined. (**Sitting, Standing, Prone/Supine**) If the patient could not be examined for curvatures, blacken in the "**Unable to Examine**" triangle and explain why in the "**Notes**" area provided in this section (Section III) of the form.

Horizontal Planes (diagram): can be used to indicate levelness of landmarks, such as mastoid processes, shoulders, inferior angle of the scapula, iliac crests, and the superior border of the greater trochanters. (This same diagram also can be used to denote such things as lateral curvatures, the AP weight-bearing line, or any other documentation that may be helpful.)

Section III: Notes, General Appearance, Cardiovascular, Lymphatics, and Neurologic and Psychiatric Evaluation

Notes: This lined box is for your personal use. It can expand and identify any of the items from any of the other Sections of the form.

General Appearance: Fill in the rectangle labeled **Y** (yes) if the patient's general appearance is **Normal**. This evaluation may include: development, nutrition, body habitus, deformities, and attention to grooming. If the patient's general appearance is not normal, fill in the rectangle labeled **N** (no) and write your observations in the "**Notes**" portion of this section.

Cardiovascular: Fill in the rectangles labeled **Y** (yes) if examination of the peripheral vascular system by **Observation** (e.g. swelling, varicosities) and **Palpation** (e.g. pulses, edema, tenderness) of the legs and arms reveal normal findings. If examination of the patient's peripheral vascular system is abnormal, fill in the rectangle labeled **N** (no) and write your findings in the "**Notes**" portion of this section.

Lymphatics: If palpation of lymph nodes in the neck, axillae, groin and/or other locations is negative, then fill in the rectangle labeled **Y** (yes) next to "**No palpable nodes**". If lymph nodes are palpated, fill in the rectangle labeled **N** (no) and write your findings in the "**Notes**" portion of this section.

Neurological/Psychiatric:

Coordination intact: If when testing coordination (e.g. Finger-to-nose, heel/knee/shin, rapid alternating movements of the upper and lower extremities, evaluation of fine motor coordination) you find the patient's coordination intact, fill in the rectangle labeled **Y** (yes). If abnormalities are found on exam, fill in the rectangle labeled **N** (no) and write the findings in the "**Notes**" portion of this section.

Sensory intact: If your evaluation for sensation (e.g. by touch, pin prick, vibration, proprioception) is normal, fill in the rectangle labeled **Y** (yes). If abnormalities are found on exam, fill in the rectangle labeled **N** (no) and write your specific findings in the "**Notes**" portion of this section.

Mental Status (Oriented: In time, In person, In place): If your patient is oriented in each of these items (time, person, place), fill in the rectangle labeled **Y** (yes). If abnormalities are found on exam, fill in the rectangle labeled **N** (no) and write your specific findings in the "**Notes**" portion of this section.

Good Mood / Affect : If your patient has a **Good mood** and **affect**, fill in the rectangle labeled **Y** (yes). If abnormalities are found on exam, fill in the rectangle labeled **N** (no) and write your specific findings in the "**Notes**" portion of this section.

Note: If you fill in all the rectangles labeled Y (yes) in this section, you denote that this is a normal examination for General Appearance, Cardiovascular, Lymphatics, and Neurologic/Psychiatric Evaluations.

Section IV: Short Leg, Skin, Level of SOS, Reflexes and Motor

Short Leg: With the patient in a supine position, evaluate for equal leg length using the medial malleolus as a reference point. If equal, fill in the rectangle labeled **Equal**. If a short leg seems to be present, fill in the rectangle that's closest to the fractional discrepancy (1/8, 1/4, 1/2 inch) and indicate the short side (**Right** or **Left**).

Skin: Record results of your inspection and/or palpation of the skin and subcutaneous tissues. If the tissues are normal, fill in the rectangle labeled **N** (normal) for each area. If the tissues are abnormal, fill in the rectangle labeled **Ab** (abnormal) for each area.: 1. **Head / Neck**, 2. **Trunk**, 3. **L. upper extremity**, 4. **R. upper extremity,** 5. **L. lower extremity** and 6. **R. lower extremity**. Specific abnormalities should be written in the "**Notes**" portion of this section.

Level of SOS (Single Organ System)*:* This is a guide for criteria needed to justify your evaluation and management CPT code in the **O**bjective section. For the Single Organ System Musculoskeletal Examination to be coded comprehensively, all sections designated with an asterisk in the extreme left margin of the form need to be filled in. Such starred areas include the following: Constitutional (includes **Vital Signs** and **General Appearance**), **Cardiovascular**, **Lymphatics**, **Neurologic and Psychiatric**, **Skin**, **Reflexes**, the **Musculoskeletal exam table, Gait and Station**. See the CPT book for details and definitions of elements. Fill in the rectangle that represents the level that applies.

- **II** **1-5 elements:** For a level two (99202) visit you must have examined one to five elements identified in a starred section.
- **III** **6+ elements:** For a level three (99203) visit you must have examined at least six elements identified in a starred section.
- **IV** **12+ elements for musculoskeletal ex.:** For a level four (99204) visit you must have done an examination of at least twelve elements identified by a star.
- **V** **Perform all elements** (* = starred**):** For a level five (99205) visit you must perform all elements identified by a star. If you fill in **all the starred sections** on the form, you will have more than enough information to justify a level-5 examination.

Be advised for the **Single Organ System Musculoskeletal Exam**, the six areas are: 1) head, face, and neck; 2) spine, ribs and pelvis; 3) right upper extremity; 4) left upper extremity; 5) right lower extremity; 6) left lower extremity.

Warning: For the comprehensive level of exam, all four of the elements identified in **TART** must be performed and documented for each of four of the six anatomic areas. For the three lower levels of examination, each element is counted separately for each body area. For example, assessing range-of-motion in two extremities constitutes two elements.

Reflexes: These are graded on an increasing scale from 0-4 according to the estimated strength of the muscle contraction, where 0 indicates no reflex, 1 indicates hyporeflexia, 2 indicates normal reflex, 3 indicates hyperreflexia, and 4 indicates clonus. Fill in the appropriately labeled rectangle for each of the reflexes (**Biceps,**

Triceps, Brachioradialis, Patellar, Achilles and **Babinski**). The **Babinski** reflex can be marked as an up-going (**up**) or down-going (**down**) response. For each reflex, indicate test results for the right (**R**) and the left (**L**) sides.

Motor: These are graded on an increasing scale from 1-5 according to the estimated strength of muscle contraction. A "**1**" is the weakest and a "**5**" is normal. Fill in the appropriately labeled rectangle for each of the nerve roots (C5, C6, C7, C8, T1, L4, L5, S1). For each nerve root indicate test results for the left (**L**) and right (**R**) sides.

Section V: 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 are the criteria required for coding in each body area:

- **All:** This indicates that all **TART** criteria was used to examine a region
- **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 and Other Systems** section of this table.

Region Evaluated: This is a list of musculoskeletal body regions arranged in order based on the CPT examination documentation requirements. They include: ***1. Head and Face**, and **Neck**; ***2.** Spine (**Thoracic, Ribs, Lumbar, Sacrum/Pelvis, Pelvis/Innom.** and **Abd./Other**), ***3. Right upper extremity**, ***4. Left Upper Extremity**, ***5. Right Lower Extremity** and ***6. Left Lower Extremity**. The thoracic region is broken down into three parts based on vertebral levels for innervation specificity: **T1-4**, **T5-9** and **T10-12**. This provides ease in listing interrelationships between musculoskeletal findings and possible involvement of the visceral system.

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 rectangle for each region examined. For regions that are not examined leave the rectangle 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**; in particular **R**ange of motion (**R**) and/or **T**issue Texture Change (**T**) may or may not be overtly symptomatic.
3 Severe ..... Key Lesions observed, significant, symptomatic, stands out; **R** and/or **T** elements stand out with minimum search or provocation.

(At the top of the table is a **Key to the Severity Scale**, which provides for a quick review.)

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 (PNS), lymphatic (LYM), cardiovascular (CV), respiratory (RESP), gastrointestinal (GI), fascial (FAS), etc., components. Use standard terminology.

If you filled in rectangles under **TART** you do not need to write anything here for coding purposes; however, this section is useful for recording notes for personal use.

Signature of examiner: Signature of the attending physician is mandatory. Also, the transcriber should sign if this is appropriate.

Page 3 of 3:

Outpatient Osteopathic Assessment and Plan Form

This page of the system is to be used with the Outpatient Osteopathic SOS History/Exam Form and the Outpatient Osteopathic SOS Musculoskeletal Exam Form. It contains the **A**ssessment and **P**lan for completion of a SOAP note. It provides for the **Written Diagnosis**, **Physician's evaluation of patient prior to treatment,** treatment **table for OMT,** other instructions and treatments given, coding instructions, **Minutes spent with the patient**, **Follow-up**, **OMT performed**, **Other Procedures Performed** and **E/M Code**.

A: the **A**ssessment section for the SO**A**P note. This includes patient's name, date, diagnosis, and physician's evaluation of patient prior to treatment.

Section I: Patient's Name and Date

Patient's Name: Write in the patient's first and last name.

Date: Write in the date of the patient's visit (month/day/year).

The boxes marked "**Office of:**" and "**For office use only:**" can be used to identify research studies, office record keeping, etc.

Section II: Diagnosis and Evaluation Prior to Treatment

Dx No. (diagnosis number)*:* Write in your priority numbers in the **Dx No.** columns with "1" being the number of your most severe or addressed diagnosis for this visit.

ICD Code: Write in this column the ICD code that corresponds to your diagnosis, if it has not already been written in.

Written Diagnosis: Write on this line the description for each of your ICD codes, if not already listed.

Physician's Evaluation of Patient Prior to Treatment: This is the physician's overall opinion of how well the patient is doing based on objective findings of the patient prior to treatment compared to the previous visit(s).

First visit: If this is the patient's first visit for a particular problem, mark the rectangle after **First visit**.

Resolved: If the problem for which a follow-up visit was requested is resolved, mark the rectangle after **R**esolved. Example: If a patient presents for a follow up on a musculoskeletal problem, filling in the **Resolved** rectangle implies that the region of the previous somatic dysfunction was evaluated, with no abnormal findings found, and that you also filled in the **0** (zero) rectangle in the severity column for that region in the Musculoskeletal Table (found on page 2 of 3).

Improved: If the problem for which a follow-up visit was requested is improved but not totally resolved, mark the rectangle after **I**mproved.

Unchanged: If the problem for which a follow-up visit was requested is no different or completely unchanged from the prior visit, mark the **U**nchanged rectangle. This implies that, for a musculoskeletal problem, the general severity of the overall somatic findings is similar to that at the last visit. This may also apply if you evaluate or consult on a patient at one visit but do not institute any treatment at that visit.

Worse: If the problem for which a follow-up visit was requested is worse then it was at the last visit, mark the rectangle after **W**orse. This could occur with a musculoskeletal problem if no treatment was started at the prior 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 the patient's condition at the current visit. This does not reflect whether the patient had an early delayed response, i.e. a flare-up, from the last treatment. Flare-up information can be charted in the **S**ubjective section of the note.

Section III: Plan: Region, OMT, Treatment Method, and Response

P: the **P**lan Section of the SOA**P** form. This includes a treatment table for Osteopathic Manipulative treatment. Following the table, it also records **Meds** (medications), **Exercise**, **Nutrition**al advice, and **PT** (physical therapy) instructions. "**Other**" provides space for any

additional advice or type of treatment you institute. Also included in this section are areas for coding, **Minutes spent with patient**, **Follow-up**, **OMT performed**, **Other Procedures Performed**, and **EM/Code**s.

Region lists musculoskeletal body regions arranged in order based on the CPT categories. They include: **Head and Face, Neck, Thoracic, Ribs, Lumbar, Sacrum, Pelvis, Abdomen/Other** (viscera falls into this category), **Upper Extremities, Lower Extremities**. If no regions are treated, fill in the "**All not done**" rectangle.

OMT: Fill in the **Y**es rectangle for each region in which an examination was performed and Osteopathic Manipulative Treatment (OMT) was given. Fill in the **N**o rectangle if OMT was not performed on a region that was examined. Note: For each region treated, there must be rectangles for **Methods Used for Examination** and **Severity** rectangles (1,2, or 3) filled in for that region of the body examined on the Musculoskeletal Table (found on page 2 of 3).

Treatment Method: Listed here are the abbreviations of manipulative treatment modalities, approved by the profession and included in the Glossary of Osteopathic Terminology, for treatment of the somatic dysfunctions listed previously. Fill in the rectangles that correspond to the modalities used to treat each region.

ART:	articulatory treatment
BLT:	balanced ligamentous tension / 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 (thrust treatment)
IND:	indirect treatment
INR:	integrated neuromuscular release
LAS:	ligamentous articular strain/balanced ligamentous tension treatment
ME:	muscle energy treatment
MFR:	myofascial release treatment
ST:	soft tissue treatment
VIS:	visceral manipulative treatment
OTH:	any other OMT treatments used

Response: Fill in one of these rectangles for each region of somatic dysfunction that was treated with OMT. This is the physician's 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 **R**esolved without evidence of it having ever been present.
- **I:** The somatic dysfunction is **I**mproved but not completely resolved.
- **U:** The somatic dysfunction is **U**nchanged or the same after treatment as it was before treatment.
- **W:** The somatic dysfunction is **W**orse or aggravated immediately after treatment.

Section IV: Other Treatment Methods Used

Meds: List in this space any medications the patient will continue on or new medication that will be started. Risks, benefits and potential side effects can be listed here.

Exercise: List in this space any exercises you wish the patient to continue or add to their treatment prescription and whether they were discussed, taught or given handouts.

Nutrition: List in this space any nutritional, food, or diet recommendations that you have given or will give your patient.

PT: List in this space any Physical Therapy modalities your patient currently receives, has received in the office, or that you recommend they receive or do.

Other: List in this space anything that doesn't fit into any of the other categories. For example, counseling could be addressed in this section. If 50% or more of your time spent with the patient was spent in counseling or educating the patient, specifically list what topics were discussed, what details were included, what handouts or educational material were given and what referrals were made.

Section V: Coding

Complexity / Assessment / Plan (Scoring): Three of the following three categories (**Problems, Risk, Data**) are required for an established visit. Note that there are five levels and five rectangles below the list for each category. Add up the total points earned from each category. Record the total for each category by blackening the appropriate rectangle under one of the five levels. The total level for complexity is the average of the three categories included (Problems, Risk, and Data).

Problems: Find which criteria match this visit. This could be **Self-limited**, **Established problem improved / stable**, **Established—worsening**, **New—no workup**, or **New additional workup**. Add points or number of problems that fit this patient in each category. Find the total points under one of the five levels and blacken the appropriate rectangle.

Risk: Find which criteria match this visit. This could be **Minimal**, **Low**, **Moderate**, or **High** based on presenting problems, diagnostic procedures, and management options. Find the level of risk under one of the five levels and blacken the appropriate rectangle.

Data: Find which criteria match this visit. This could be **Lab**, **Radiology**, **Medicine**, **Discuss with performing physician**, **Obtain records or Hx from others**, **Review records**, **discuss with physician**, or **Visualization of tracing** or **specimen**.

Add up the total points for all the categories (**Problems**, **Risk** and **Data**). Find the total points for each category under one of the five levels and blacken the appropriate box. Only two of the three categories are required. The total level for complexity is the average of the categories included.

Traditional Method—Coding by Components:

For each **History**, **Examination** and **Complexity/ Assessment / Plan** section, put a circle around the appropriate composite level. All three areas are required for new patient visits. Then blacken the rectangle in the **Final Level of Service** that denotes the average of the three levels recorded.

Optional Method—Coding by Time:
When the majority of the Encounter (50% or greater) **is counseling/coordinating, the level is determined by total time**. Blacken the rectangle that indicates how much time was spent counseling: **New patients (minutes)**—10, 20, 30, 45, 60; **Established patients (minutes)**— 10, 15, 25, 40. Be sure in your plan to write a brief description of topics discussed. (Also be sure to blacken the appropriate rectangle that corresponds to the total time spent with the patient—see the next paragraph.)

Section VI: Minutes Spent With the Patient, Follow-up, Units, OMT Performed as above (number of areas), **Other Procedures Performed** and **E/M Code**

Minutes Spent With the Patient: Blacken the rectangle 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, >60 minutes). This corresponds to the time allotments in the CPT book. Choose the rectangle that best fits your total time.

Follow-up: Blacken the rectangles that correspond to when you would like to see the patient again; you must indicate both the number and the **Units**. For example: for a visit in one month, blacken the rectangle above the "**1**" and also the box above **M** (month). Abbreviations following the **Units** title are: **D** (days), **W** (week), **Y** (year), and **PRN** (as needed).

OMT Performed as Above: Fill in the rectangle for the number of regions with somatic dysfunction that were treated. Note: This number should correlate with the number of YES rectangles in the OMT section of the table on page 3 of 3, and the number of rectangles in the severity section of the table on page 2 of 3 marked as 1, 2, or 3. The rectangles are defined as follows:

0 areas: You treated NO (zero) regions of somatic dysfunction with Osteopathic Manipulative Treatment.
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**.**

Other Procedures Performed: In the spaces provided write in the **CPT Code** and written diagnosis (**Written Dx**) for each procedure performed, other than OMT.

E/M Code: Blacken the rectangle that corresponds to the evaluation and management code for your final level of service. For a new patient visit (**New**) use 99202, 99203, 99204, 99205. For an established patient visit (**EST**) use 99211, 99212, 99213, 99214, 99215. For a consultation visit (**Consults**) use 99241, 99242, 99243, 99244, 99245.

Signature of examiner: Signature of the attending physician is mandatory. Also, the transcriber should sign if this is appropriate.

D:\Sleszynski\ SOAP Note Series Usage Form
Version *5:091102b*

Outpatient Health Summary

wak SOS version 5:091102b

Patient's Name Jamie Smith		**Date** 11/20/01	**Update:**	
Date of Birth 9/13/1976	**Sex** F	**Phone Numbers:**	**Home** 262-657-5975	
Marital Status: M (S) D W			**Work** 847-595-2714	
Significant Others: Boyfriend--John		**DNR Status: Resuscitate?**	X **Yes** **No**	**Qualifications:** Unless brain dead
Religion: Catholic		**Next of Kin:** Gordon and Shirley Smith--parents		

Social History:	**Employment** Abbott Labs	**Occupation** Secretary	**Education** College x 4 yrs.	
	Tobacco Quit 1999	**ETOH** 2 beers per wk	**Drugs** past pot	**Sex Hx** G 1, P 0010
				Reg. menses
Family History:	**M** ↑ Hypothyroid	**Siblings** 1 brother A & W	**Others:** Maternal GM ↓ breast CA	
	F ↓46 yrs. MI and PUD	1 sister Asthma		

Past Medical History

CPT#	Start Date	Problem / Diagnosis	Medications	Start	Stop
		Sciatica	Proventil inhaler PM	1999	
564.1		IBS	Advil 400 mg TID	9-01	
493.00		Asthma	Synthroid 0.125mg po qd	2000	
244.9	2000	Hypothyroidism	St. John's Wort	10-01	
	1985	MVA Ø injury	Vit. B6. E. B12. C		
250.01		DM Type I	Norflex 100 mg po BID	10/01	
847.1	10/01	Thoracic strain			

Allergies, Adverse Drug Reactions: PCN – rash Cat dander, ragweed

Health Maintenance

Parameter	Dates							
DPT/DT/TD	1976	1-77	3-77	1982	1992			
OPV	11-76	1-77	3-77	1982				
MMR	1977							
HIB	11-76	1-77	3-77					
Influenza								
Hepatitis	2-83	3-82	9-82					
PPD/Tine								
Pneumovax								
H & P	2000							
Eye exam	3 / 01							
Dental exam	6 / 01							
PAP smear	2000							
Mammogram								
Urinalysis	2000							
Hemoccult								
Cholesterol	2000/189							
Sigmoidoscopy								
Others CXR	6-01							

Past Surgical History

Date	Type
Child	T and A
1991	Wisdom teeth x 4
1980	Sutures Rt. forearm
1993	Fx right wrist

Consultants

PCP	Inveiss
GYN	Azuma

Funded by a grant from the Bureau of Research.
Designed to coordinate with the Established Outpatient Osteopathic SOAP Note Form. Recommended by American Association of Colleges of Osteopathic Medicine.

Outpatient Osteopathic SOS History / Exam Form

wak SOS version 5:091102b

Patient's Name Jamie Smith **Date** 11 / 20 / 01

Office of:	
For office use only:	

HISTORY

S (See Outpatient Health Summary Form for details of history)

Patient's Pain Analog Scale: ☐ Not done

Left hip | Low back

NO PAIN — WORST POSSIBLE PAIN

CC "Low back and hip pain"

Hands on chiro worked better than activator. Never tried PT

Diet—high CHO, few veggies

1993—Fx Rt wrist—fell off bike

History of Present Illness **Level: HPI**

Elements		
☐	Location	Central low-back and Lt. hip
☐	Quality	Achy, dull
☐	Severity	5 / 10 LBP, 1-3 / 10 Lt. hip
☐	Duration	x 3 months
☐	Timing	Occurred suddenly
☐	Context	Happened while putting her sox on
☐	Modifying factors	Chiro, massage/heat helps; ↑ with walking
☐	Assoc. Signs and Sx	↑ constipation when LBP is worse

OR Status of ≥ 3 chronic or inactive conditions

Blood sugars—stable

☐	II / III	1-3 elements reviewed
▌	IV / V	≥ 4 elements OR status of ≥ 3 chronic conditions

Review of Systems (Only ask / record those systems pertinent for this encounter.) ☐ Not done **Level: ROS**

▌	Constitutional (Wt loss, etc.)	Fatigue
▌	Eyes	Glasses
▌	Ears, nose, mouth, throat	Chronic sinus problem
▌	Cardiovascular	No palpitations
▌	Respiratory	Asthma been worse lately
▌	Gastrointestinal	IBS primarily with pain and constipation
▌	Genitourinary	without incontinence
▌	Musculoskeletal	See above
▌	Integumentary (skin, breast)	
▌	Neurological	No headaches
▌	Psychiatric	Depression for 5 yrs., situation related
▌	Endocrine	Hypothyroidism—last lab work 1 year ago
▌	Hematologic/lymphatic	
▌	Allergic/immunologic	Has asthma

☐	II	None
☐	III	1 system pertinent to the problem
☐	IV	2-9 systems
▌	V	≥ 10 systems

Past Medical, Family, Social History ☐ Not done **Level: PFSH**

▌	Past history / trauma	Forceps delivery, 1990 fell off horse onto tailbone
		1985 MVA rear-ended, +ER, +seat belt, no injury
▌	Family history	See Health Summary Form
▌	Social history	

☐	II / III	None
☐	IV	1 history area
▌	V	≥ 2 history areas

Overall History = Average of HPI, ROS or PFSH: ☐ **II** (1-3 HPI) ☐ **III** (1-3 HPI, 1 ROS) ☐ **IV** (4+ HPI, 2-9 ROS, 1 PFSH) ▌ **V** (4+ HPI, 10+ ROS, 2+ PFSH)

O Lungs—expiratory wheeze bilaterally, Ó accessory muscle use or SOB

Lumbar x-rays reviewed—disc space narrowing at L5-S1 area

Signature of transcriber: _____ Signature of examiner: SLSleszynskiDO

Funded by a grant from the Bureau of Research.

Designed to coordinate with the Established Outpatient Osteopathic SOAP Note Form. Recommended by American Association of Colleges of Osteopathic Medicine.

Outpatient Osteopathic SOS Musculoskeletal Exam Form

wak SOS version 5:091102b

O ☐ Not done

Patient's Name Jamie Smith **Date** 11/20/01 Sex: Male ☐ Female ▌

Age 25 * Vital Signs (3 of 7) Wt. 125 lb Ht. 5' 2" Temp. 97.6

Reg. ▌ Pt. position for recording BP:

Resp. 20 Pulse 84 Irreg. ☐ Standing _____ Sitting 124/86 Lying _____

Office of:

For office use only:

* **Gait and Station:**

Body Type: Endo. ☐ Meso. ▌ Ecto. ☐

Posture: Excl. ☐ Fair ▌ Poor ☐

Gait: Symmetrical ☐ Asymmetrical ▌

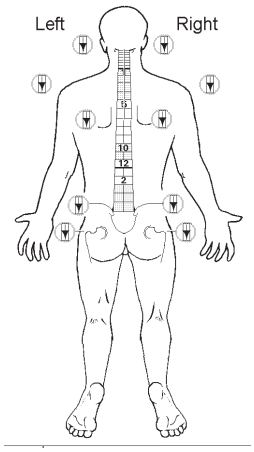
Ant./Post. Spinal Curves:

	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	☐		



Horizontal Planes

Notes

Gait forward bent
Facial acne
Rt forearm scar
Dull affect

* Gen. Appearance: **Y** **N**

Normal ☐ ▌

***Cardiovascular**

Observation normal ▌ ☐

Palpation normal ▌ ☐

***Lymphatics**

No palpable nodes ▌ ☐

***Neurologic and Psychiatric:**

Coordination intact ▌ ☐

Sensory intact ▌ ☐

Mental status

Oriented:

In time ▌ ☐

In person ▌ ☐

In place ▌ ☐

Good mood/ affect ☐ ▌

Short leg? Equal ☐

Right:	1/8 ☐	¼ ☐	½ ☐
Left:	1/8 ▌	¼ ☐	½ ☐

Level of SOS

☐	**II**	1-5 elements
☐	**III**	6+ elements
☐	**IV**	12 elements for musculoskeletal exam
▌	**V**	Perform all * elements

* **Skin:**

	N	Ab		N	Ab		N	Ab
Head / neck	☐	▌	L. upper extremity	▌	☐	L. lower extremity	☐	☐
Trunk	▌	☐	R. upper extremity	☐	▌	R. lower extremity	☐	☐

* **Reflexes:**

		0	1	2	3	4
Biceps	L	☐	☐	▌	☐	☐
	R	☐	☐	▌	☐	☐
Triceps	L	☐	☐	▌	☐	☐
	R	☐	☐	▌	☐	☐
Brachio-Radialis	L	☐	☐	▌	☐	☐
	R	☐	☐	▌	☐	☐

		0	1	2	3	4
Patella	L	☐	☐	☐	▌	☐
	R	☐	☐	☐	▌	☐
Achilles	L	☐	☐	☐	▌	☐
	R	☐	☐	▌	☐	☐
Babinski	L	up ☐		down ▌		
	R	up ☐		down ▌		

Motor:

		1	2	3	4	5
C5	L	☐	☐	▌	☐	☐
	R	☐	☐	▌	☐	☐
C6	L	☐	☐	▌	☐	☐
	R	☐	☐	▌	☐	☐
C7	L	☐	☐	▌	☐	☐
	R	☐	☐	▌	☐	☐
C8	L	☐	☐	▌	☐	☐
	R	☐	☐	▌	☐	☐

		1	2	3	4	5
T1	L	☐	☐	☐	☐	▌
	R	☐	☐	☐	☐	▌
L4	L	☐	☐	☐	☐	▌
	R	☐	☐	☐	☐	▌
L5	L	☐	☐	☐	☐	▌
	R	☐	☐	☐	☐	▌
S1	L	☐	☐	☐	▌	☐
	R	☐	☐	☐	☐	▌

Key to the Severity Scale

0 = No SD or background (BG) levels
1 = More than BG levels, minor TART
2 = Obvious TART (esp. R and T), +/- symptoms
3 = Key lesions, symptomatic, R and T stand out

	Methods Used For Examination					Region Evaluated	Severity				*Somatic Dysfunction and Other Systems*
	All	T	A	R	T		0	1	2	3	MS / SNS / PNS / LYM. / CV / RESP. / GI / FAS. / etc.
*1	▌	☐	☐	☐	☐	Head and Face	☐	▌	☐	☐	Lt SBS torsion
	☐	☐	☐	☐	☐	Neck	☐	☐	☐	▌	C2 TART Rt. C7 F SRL
	☐	▌	☐	☐	☐	Thoracic T1-4	☐	☐	▌	☐	DMC T3 Rt.
	▌	☐	☐	☐	☐	T5-9	☐	☐	☐	☐	
	▌	☐	☐	☐	☐	T10-12	☐	▌	☐	☐	
*2	☐	☐	☐	☐	▌	Ribs	☐	☐	▌	☐	Tender lower left
	▌	☐	☐	☐	☐	Lumbar	☐	☐	☐	▌	L5 F S RL
	▌	☐	☐	☐	☐	Sacrum / Pelvis	☐	☐	☐	▌	Tight piriformis Lt.
	▌	☐	☐	☐	☐	Pelvis / Innom.	☐	☐	▌	☐	Ant. Ilium Lt.
	☐	▌	☐	▌	▌	Abd ./ Other	☐	▌	☐	☐	Palpable bowel, poor movement, tender RLQ
*3	☐	☐	☐	☐	☐	Upper R	☐	☐	☐	☐	
*4	☐	☐	☐	☐	☐	Extremity L	☐	☐	☐	☐	
*5	▌	☐	☐	☐	☐	Lower R	▌	☐	☐	☐	WNL
*6	▌	☐	☐	☐	☐	Extremity L	☐	☐	☐	▌	+ straight leg raising, ↓ cuboid

Signature of transcriber: _____

Signature of examiner: SLSleszynskiDO

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Designed to coordinate with the Established Outpatient Osteopathic SOAP Note Form. Recommended by American Association of Colleges of Osteopathic Medicine.

Outpatient Osteopathic Assessment and Plan Form

wak SOS version 5:091102b

Office of:	
For office use only:	

A **Patient's Name** Jamie Smith **Date** 11 / 20 / 01

Physician's evaluation of patient prior to treatment: First visit ▌ Resolved ☐ Improved ☐ Unchanged ☐ Worse ☐

Dx No.	ICD Code	Written Diagnosis	Dx No.	ICD Code	(Written Diagnosis)
1	722.10	Sciatica possible herniated disc with myelopathy	6	493.00	Asthma
2	781.0	Spasm—psoas syndrome			
5	564.1	IBS			
10	244.9	Hypothyroidism			
14	739.0	Somatic Dysfunction of Head and Face	4	739.4	Somatic Dysfunction of Sacrum
11	739.1	Somatic Dysfunction of Neck	7	739.5	Somatic Dysfunction of Pelvis
12	739.2	Somatic Dysfunction of Thoracic	9	739.9	Somatic Dysfunction of Abd / Other
13	739.8	Somatic Dysfunction of Ribs		739.7	Somatic Dysfunction of Upper Extremity
3	739.3	Somatic Dysfunction of Lumbar	8	739.6	Somatic Dysfunction of Lower Extremity

P ☐ All not done

Region	OMT Y	OMT N	ART	BLT	CR	CS	DIR	FPR	HVLA	IND	INR	LAS	ME	MFR	ST	VIS	OTH	Response R	I	U	W
Head and Face	☐	▌	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Neck	☐	▌	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Thoracic T1-4	☐	▌	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
T5-9	☐	▌	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
T10-12	☐	▌	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Ribs	☐	▌	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Lumbar	▌	☐	☐	☐	☐	☐	☐	☐	▌	☐	☐	☐	☐	☐	▌	☐	☐	▌	☐	☐	☐
Sacrum	▌	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	▌	☐	▌	☐	☐	☐	▌	☐	☐
Pelvis	▌	☐	▌	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	▌	☐	☐	☐
Abdomen/Other	☐	▌	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Upper Extremity	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Lower Extremity	☐	▌	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Meds: Use Proventil inhaler regularly q 4 hr. x 3 d
Add Flexeril 10 mg PO tid, Continue Advil tid

PT: Use warm salt bath daily
Use lumbar support at work

Exercise: Psoas stretch, walk—gradually ↑ time
Constant rest position

Other: OMT q 1 wk x 6 visits
Obtain TSH level, PFT
Refer to Psychologist
Obtain MRI Lumbar spine—script given, letter PCP done

Nutrition: ↑ protein in diet, add veggie supplement

Complexity / Assessment / Plan (Scoring) *Default to level 2—same criteria

Problems		Risk: (presenting problem(s), diagnostic procedure(s) and management options	Data	Maximum points
Self-limiting	1 (2 max.)		Lab TSH	1
Established problem improved / stable	1	Minimal = Min.	Radiology MRI	1
Established—worsening	2	Low	Medicine PFT	1
New—not problem	3 (3 max.)	Moderate = Mod.	Discuss with performing physician	1
New additional workup	4	High Meds, 3 chronic and 1 new problem	Obtain records or Hx from others	1
		MRI and Lab	Review records, discuss with physician	2
			Visualization of tracing, specimen	2

Level I	Level II	Level III	Level IV	Level V	Level I	Level II	Level III	Level IV	Level V	Level I	Level II	Level III	Level IV	Level V
*	≤1 pt.	2 pt.	3 pt.	≥4 pt.	*	Min.	Low	Mod.	High	*	≤1 pt.	2 pt.	3 pt.	≥4 pt.
	☐	☐	☐	▌		☐	☐	☐	▌		☐	☐	☐	▌

Requires only 3 above 3 (problems, risk and data). Level of complexity = average of included areas.

Traditional Method—Coding by Components

	I	II	III	IV	V
History					
Examination					
Complexity / Assessment Plan					
Final level of service	☐	☐	☐	☐	▌

All three areas required. Average of the three equals level of service.

Optional Method—Coding by Time

When majority of the encounter is counseling / coordinating, the level is determined by total time

	I	II	III	IV	V
New patients (minutes)	10	20	30	45	60
Outpatient consults (minutes)		10	15	25	40
Final level of service	☐	☐	☐	☐	☐

Dictate total time and counseling / coordinating time plus a brief description of topics discussed

Minutes spent with the patient: ☐ 10 ☐ 15 ☐ 25 ☐ 40 ▌ 60 ☐ >60

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

Units: ☐ D ▌ W ☐ M ☐ Y ☐ PRN

OMT performed as Above: 0 areas ☐ 1-2 areas ☐ 3-4 areas ▌ 5-6 areas ☐ 7-8 areas ☐ 9-10 areas ☐

Other Procedures Performed: CPT Codes: 97010 | Written Dx: Hot Packs

E/M Code: New ☐ 02 ☐ 03 ☐ 04 ▌ 05 . . . EST ☐ 11 ☐ 12 ☐ 13 ☐ 14 ☐ 15 . . . **Consults** ☐ 41 ☐ 42 ☐ 43 ☐ 44 ☐ 45

Write 992 plus . . .

Signature of transcriber: _____

Signature of examiner: SLSleszynskiDO

Designed to coordinate with the Established Outpatient Osteopathic SOAP Note Form. Recommended by American Association of Colleges of Osteopathic Medicine.

Outpatient Health Summary

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Patient's Name		**Date**	**Update:**	
Date of Birth	**Sex**	**Phone Numbers:**	**Home**	
Marital Status: M S D W			**Work**	
Significant Others:		**DNR Status: Resuscitate?**	**Yes** / **No**	**Qualifications:**
Religion:		**Next of Kin:**		

Social History:	**Employment**	**Occupation**	**Education**	
	Tobacco	**ETOH**	**Drugs**	**Sex Hx**
Family History:	**M**	**Siblings**	**Others:**	
	F			

Past Medical History

CPT#	Start Date	Problem / Diagnosis	Medications	Start	Stop

Allergies, Adverse Drug Reactions: _____

Health Maintenance

Parameter	Dates							
DPT/DT/TD								
OPV								
MMR								
HIB								
Influenza								
Hepatitis								
PPD/Tine								
Pneumovax								
H & P								
Eye exam								
Dental exam								
PAP smear								
Mammogram								
Urinalysis								
Hemoccult								
Cholesterol								
Sigmoidoscopy								
Others								

Past Surgical History

Date	Type

Consultants

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Outpatient Osteopathic SOS History/Exam Form

wak SOS version 5:091102b

Office of:	
For office use only:	

Patient's Name _____ **Date**_____

HISTORY

S (See Outpatient Health Summary Form for details of history)

Patient's Pain Analog Scale: ☐ Not done

NO PAIN — WORST POSSIBLE PAIN

CC

History of Present Illness **Level: HPI**

Elements		
☐	Location	
☐	Quality	
☐	Severity	
☐	Duration	
☐	Timing	
☐	Context	
☐	Modifying factors	
☐	Assoc. Signs and Sx	

OR Status of ≥ 3 chronic or inactive conditions

_____

_____

_____

☐	**II** / **III**	1-3 elements reviewed
☐	**IV** / **V**	≥ 4 elements OR status of ≥ 3 chronic conditions

Review of Systems (Only ask / record those systems pertinent for this encounter.) ☐ Not done **Level: ROS**

☐	Constitutional (Wt loss, etc.)
☐	Eyes
☐	Ears, nose, mouth, throat
☐	Cardiovascular
☐	Respiratory
☐	Gastrointestinal
☐	Genitourinary
☐	Musculoskeletal
☐	Integumentary (skin, breast)
☐	Neurological
☐	Psychiatric
☐	Endocrine
☐	Hematologic/lymphatic
☐	Allergic/immunologic

☐	**II**	None
☐	**III**	1 system pertinent to the problem
☐	**IV**	2-9 systems
☐	**V**	≥ 10 systems

Past Medical, Family, Social History ☐ Not done **Level: PFSH**

☐	Past History / Trauma
☐	Family History
☐	Social History

☐	**II** / **III**	None
☐	**IV**	1 history area
☐	**V**	≥ 2 history areas

Overall History = Average of HPI, ROS or PFSH: ☐ **II** (1-3 HPI) ☐ **III** (1-3 HPI, 1 ROS) ☐ **IV** (4+ HPI, 2-9 ROS, 1 PFSH) ☐ **V** (4+ HPI, 10+ ROS, 2+ PFSH)

O

Signature of transcriber: _____ Signature of examiner: _____

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Outpatient Osteopathic SOS Musculoskeletal Exam Form

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O ☐ Not done

Patient's Name _____ **Date** _____ Sex: Male ☐ Female ☐

Age _____ * Vital Signs (3 of 7) Wt. _____ Ht. _____ Temp. _____

Reg. ☐ Pt. position for recording BP:

Resp. ____ Pulse ____ Irreg. ☐ Standing_____ Sitting_____ Lying_____

Office of:	
For office use only:	

* **Gait and Station:**

Body Type: Endo. ☐ Meso. ☐ Ecto. ☐

Posture: Excl. ☐ Fair ☐ Poor ☐

Gait: Symmetrical ☐ Asymmetrical ☐

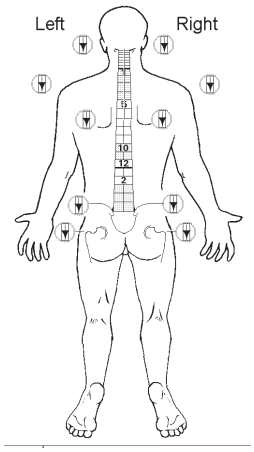
Ant./Post. Spinal Curves:

	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	☐		



Horizontal Planes

Notes

* Gen. Appearance:	Y	N
Normal	☐	☐
***Cardiovascular**		
Observation normal	☐	☐
Palpation normal	☐	☐
***Lymphatics**		
No palpable nodes	☐	☐
***Neurologic and Psychiatric:**		
Coordination intact	☐	☐
Sensory intact	☐	☐
Mental status		
Oriented:		
In time	☐	☐
In person	☐	☐
In place	☐	☐
Good mood/ affect	☐	☐

* **Short leg?** Equal ☐

Right:	1/8 ☐	¼ ☐	½ ☐
Left:	1/8 ☐	¼ ☐	½ ☐

Level of SOS

☐	**II**	1-5 elements
☐	**III**	6+ elements
☐	**IV**	12+ elements for musculoskeletal Exam
☐	**V**	Perform all * elements

Skin:

	N	Ab		N	Ab		N	Ab
Head / neck	☐	☐	L. upper extremity	☐	☐	L. lower extremity	☐	☐
Trunk	☐	☐	R. upper extremity	☐	☐	R. lower extremity	☐	☐

* **Reflexes:**

		0	1	2	3	4
Biceps	L	☐	☐	☐	☐	☐
	R	☐	☐	☐	☐	☐
Triceps	L	☐	☐	☐	☐	☐
	R	☐	☐	☐	☐	☐
Brachio-	L	☐	☐	☐	☐	☐
Radialis	R	☐	☐	☐	☐	☐

		0	1	2	3	4
Patella	L	☐	☐	☐	☐	☐
	R	☐	☐	☐	☐	☐
Achilles	L	☐	☐	☐	☐	☐
	R	☐	☐	☐	☐	☐
Babinski	L	up ☐		down ☐		
	R	up ☐		down ☐		

Motor:

		1	2	3	4	5
C5	L	☐	☐	☐	☐	☐
	R	☐	☐	☐	☐	☐
C6	L	☐	☐	☐	☐	☐
	R	☐	☐	☐	☐	☐
C7	L	☐	☐	☐	☐	☐
	R	☐	☐	☐	☐	☐
C8	L	☐	☐	☐	☐	☐
	R	☐	☐	☐	☐	☐

		1	2	3	4	5
T1	L	☐	☐	☐	☐	☐
	R	☐	☐	☐	☐	☐
L4	L	☐	☐	☐	☐	☐
	R	☐	☐	☐	☐	☐
L5	L	☐	☐	☐	☐	☐
	R	☐	☐	☐	☐	☐
S1	L	☐	☐	☐	☐	☐
	R	☐	☐	☐	☐	☐

Key to the Severity Scale

0 = No SD or background (BG) levels
1 = More than BG levels, minor TART
2 = Obvious TART (esp. R and T), +/- symptoms
3 = Key lesions, symptomatic, R and T stand out

	Methods Used For Examination						Severity				
	All	T	A	R	T	Region Evaluated	0	1	2	3	Somatic Dysfunction and Other Systems (MS / SNS / PNS / LYM. / CV / RESP. / GI / FAS. / etc.)
*1	☐	☐	☐	☐	☐	Head and Face	☐	☐	☐	☐	
	☐	☐	☐	☐	☐	Neck	☐	☐	☐	☐	
*2	☐	☐	☐	☐	☐	Thoracic T1-4	☐	☐	☐	☐	
	☐	☐	☐	☐	☐	T5-9	☐	☐	☐	☐	
	☐	☐	☐	☐	☐	T10-12	☐	☐	☐	☐	
	☐	☐	☐	☐	☐	Ribs	☐	☐	☐	☐	
	☐	☐	☐	☐	☐	Lumbar	☐	☐	☐	☐	
	☐	☐	☐	☐	☐	Sacrum / Pelvis	☐	☐	☐	☐	
	☐	☐	☐	☐	☐	Pelvis / Innom.	☐	☐	☐	☐	
	☐	☐	☐	☐	☐	Abd ./ Other	☐	☐	☐	☐	
*3	☐	☐	☐	☐	☐	Upper R	☐	☐	☐	☐	
*4	☐	☐	☐	☐	☐	Extremity L	☐	☐	☐	☐	
*5	☐	☐	☐	☐	☐	Lower R	☐	☐	☐	☐	
*6	☐	☐	☐	☐	☐	Extremity L	☐	☐	☐	☐	

Signature of transcriber: _____

Signature of examiner: _____

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Outpatient Osteopathic Assessment and Plan Form

wak SOS version 5: 5:091102b

Office of:	
For office use only:	

A **Patient's Name** _____ **Date** _____

Dx No.	ICD Code	Written Diagnosis	Dx No.	ICD Code	Written Diagnosis
	739.0	Somatic Dysfunction of Head and Face		739.4	Somatic Dysfunction of Sacrum
	739.1	Somatic Dysfunction of Neck		739.5	Somatic Dysfunction of Pelvis
	739.2	Somatic Dysfunction of Thoracic		739.9	Somatic Dysfunction of Abd / Other
	739.8	Somatic Dysfunction of Ribs		739.7	Somatic Dysfunction of Upper Extremity
	739.3	Somatic Dysfunction of Lumbar		739.6	Somatic Dysfunction of Lower Extremity

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

P

☐ All not done **Region**	OMT		Treatment Method															Response			
	Y	N	ART	BLT	CR	CS	DIR	FPR	HVLA	IND	INR	LAS	ME	MFR	ST	VIS	OTH	R	I	U	W
Head and Face	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Neck	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Thoracic T1-4	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
T5-9	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
T10-12	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Ribs	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Lumbar	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Sacrum	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Pelvis	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Abdomen/Other	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Upper Extremity	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Lower Extremity	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Meds: _____ PT: _____

Exercise: _____ Other: _____

Nutrition:

Complexity / Assessment / Plan (Scoring) *Default to level 2—same criteria

Problems		Risk: (Presenting problem(x), diagnostic procedures(s), and management options)	Data	Maximum Points
Self-limiting	1 (2 max.)		Lab	1
Established problem improved / stable	1	Minimal = Min.	Radiology	1
Established—worsening	2	Low	Medicine	1
New—no workup	3 (1 max.)	Moderate = Mod.	Discuss with performing physician	1
New additional workup	4	High	Obtain records or Hx from others	1
		Minimal = Min.	Review records, discuss with physician	2
			Visualization of tracing, specimen	2

Problems					Risk					Data				
Level I	Level II	Level III	Level IV	Level V	Level I	Level II	Level III	Level IV	Level V	Level I	Level II	Level III	Level IV	Level V
*	≤1 pt.	2 pt.	3 pt.	≥4 pt.	*	Min.	Low	Mod.	High	*	≤1 pt.	2 pt.	3 pt.	≥4 pt.
	☐	☐	☐	☐		☐	☐	☐	☐		☐	☐	☐	☐

Requires 3 of above 3 (problems, risk and data). Level of complexity = average of included areas.

Traditional Method—Coding by Components

	I	II	III	IV	V
History					
Examination					
Complexity / Assessment Plan	I	II	III	IV	V
Final level of service	☐	☐	☐	☐	☐

All three areas required. Average of the three equals level of service.

Optional Method—Coding by Time

When majority of the encounter is counseling / coordinating, the level is determined by total time

	I	II	III	IV	V
New patients (minutes)	10	20	30	45	60
Outpatient patients (minutes)		10	15	25	40
Final level of service	☐	☐	☐	☐	☐

Dictate total time and counseling / coordinating time plus a brief description of topics discussed

Minutes spent with the patient: ☐ 10 ☐ 15 ☐ 25 ☐ 40 ☐ 60 ☐ >60 **Follow-up:** ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12 **Units:** ☐ D ☐ W ☐ M ☐ Y ☐ PRN

OMT performed as Above: 0 areas ☐ 1-2 areas ☐ 3-4 areas ☐ 5-6 areas ☐ 7-8 areas ☐ 9-10 areas ☐

Other Procedures Performed: CPT Codes: _____ Written Dx: _____

E/M Code:	**New**	☐	☐	☐	☐	**EST**	☐	☐	☐	☐	☐	**Consults**	☐	☐	☐	☐	☐
Write 992 plus . . .		*02*	*03*	*04*	*05*	*. . .*	*11*	*12*	*13*	*14*	*15*	*. . .*	*41*	*42*	*43*	*44*	*45*

Signature of transcriber: _____ Signature of examiner: _____

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Designed to coordinate with the Established Outpatient Osteopathic SOAP Note Form. Recommended by American Association of Colleges of Osteopathic Medicine.