

# Musculoskeletal Nursing Assessment

Patient information										
Patient name:	Date of birth:									
Gender:	Date of assessment:									
Patient ID:	Assessor:									
Subjective assessment										
Are you experiencing any current musculoskeletal symptoms such as muscle weakness, pain, swelling, redness, warmth, or stiffness?										
How is it affecting your ability to complete daily activities?										
P (precipitating factors)										
Does anything bring on the symptom (e.g., activity, weight-bearing, rest)?										
Q (quality)										
Describe the characteristics of the pain (e.g., aching, throbbing, sharp, dull):										
R (region/radiation)										
Is the pain localized, or does it radiate to another part or area of the body?										
S (severity)										
How severe is the pain on a scale of 0-10?										
0	1	2	3	4	5	6	7	8	9	10

<b>T (timing)</b>	
When did the pain first start?	
<b>U (understanding):</b>	
What do you think is causing the pain?	
Have you ever been diagnosed with a chronic musculoskeletal disease such as osteoporosis, osteoarthritis, or rheumatoid arthritis?	
Yes	No
If yes, please describe the conditions and treatments:	
Have you ever been diagnosed with a neurological condition that affected the use of your muscles?	
Yes	No
If yes, please describe:	
Have you had any previous surgeries on your bones or muscles, such as fracture repair or knee or hip surgery?	
Yes	No
If yes, please describe:	
Are you currently taking any medications, herbs, or supplements for your muscles, bones, or the health of your musculoskeletal system?	
Yes	No
If yes, please describe:	
Have you ever had a broken bone, strain, or other injury to a muscle, joint, tendon, or ligament?	
Yes	No
If yes, please describe:	

<b>Objective assessment</b>			
<b>Gait and posture</b>			
Normal gait and balance:	Yes	No	
Postural abnormalities:	Kyphosis	Lordosis	Scoliosis
<b>Joint and muscle</b>			
Symmetry:	Present	Absent	
Swelling, redness, or deformity:	Yes	No	
Active range of motion:	Normal	Limited	
<b>Palpation findings</b>			
Tenderness:	Yes	No	
Warmth:	Yes	No	
Crepitus (without pain):	Present	Absent	
<b>Additional remarks</b>			
<b>Muscle strength testing</b>		<b>Remarks</b>	
<input type="checkbox"/> Assessed upper extremity strength			
<input type="checkbox"/> Assessed lower extremity strength			
<b>Muscle strength scale</b>			
<input type="checkbox"/> <b>0</b> - No muscle contraction. <input type="checkbox"/> <b>1</b> - Trace muscle contraction, such as a twitch. <input type="checkbox"/> <b>2</b> - Active movement only when gravity is eliminated. <input type="checkbox"/> <b>3</b> - Active movement against gravity but not against resistance. <input type="checkbox"/> <b>4</b> - Active movement against gravity and some resistance. <input type="checkbox"/> <b>5</b> - Active movement against gravity and examiner's full resistance.			
<b>Critical conditions to be addressed immediately</b>			

**Additional notes**