Assignment: Shadow Health Musculoskeletal Assessment Subjective

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HPI: Ms. Jones visits the clinics and presents with back pain, which she states started afflicting her three weeks before. She attributes the back pain to tweaking whilst lifting her friend's heavy box when the friend was moving. She posits that before the incident, she had lifted several boxes without injuring her back. Further, she states that the purpose of presenting concerns the increased and continued pain, which has impacted her daily living activities.

Social History: Ms. Jones' job is mostly supervisory, although she does report that she may have to sit or stand for extended periods...... use of tobacco, alcohol, and illicit drugs. She does not exercise

ROS:

General: Denies changes in weight, fatigue, weakness, fever, chills, and night sweats. • **Musculoskeletal**: Denies muscle weakness, pain, joint instability, or swelling. She states that she has difficulty with range of motion..... lower back has impacted her comfort while sleeping and sitting in class....... numbness, tingling, radiation, or bowel/bladder dysfunction. She denies previous musculoskeletal injuries or fractures. •

Neurologic: Denies loss of sensation, numbness, tingling, tremors, weakness, paralysis, fainting, blackouts, or seizures.

NR 509 Week 3 Shadow Health Musculoskeletal Assessment Objective:

ROS:

General: Ms. Jones is a pleasant, obese 28-year-old African American woman in no acute distress. She is alert and oriented. She maintains eye contact throughout the interview and examination.

Musculoskeletal: Bilateral upper extremities without muscle atrophy or joint deformity.

Bilateral upper extremities with full range of motion of shoulder, elbow, and

wrist....... upper extremity strength equal and 5/5 in neck, shoulders, elbows,

wrists, hands. Bilateral lower extremity strength equal and 5/5 in hip flexors, knees, and
ankles.

HPI

According to Bickley (2013) a clear, well organized clinical record is one of the most important adjuncts to patient care and gathering information using open-ended questions, then closed ended questions to prompt specific responses. This paper provides an overview of clinical reasoning and the nurse's decision making after providing a complete advanced health history and physical assessment.

It will also give insight into the nursing process and how it may enhance clinical thinking, reasoning and judgment in the nursing practice. Ms. Jones is a pleasant, 28-year-old obese African American single woman who presents for complete physical examination and evaluation for right foot injury. She is the primary source of history. Ms. Jones offers information freely and without contradiction.

Speech is clear and coherent. She maintains eye contact throughout the interview. Ms.

Jones is alert and oriented, is seated upright on the examination table, and is in no

apparent distress. She is well-nourished, well-developed, and dressed appropriately with good hygiene. Chief complaint is headache.

NR 509 Week 3 Shadow Health Musculoskeletal Assessment Rubric Shadow Health Physical Assessment Rubric

Criteria	Ratings								
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