

Line up Patient ID Label Here

**NEW PATIENT RECORD**

Today's Date \_\_\_\_\_ Pediatrician \_\_\_\_\_ Referred By \_\_\_\_\_

Parent  Guardian Name \_\_\_\_\_ Is this a second opinion?  Yes  No

Has the child seen one of our orthopedic doctors with the past 3 years?  Yes  No If yes, was it the same problem?  Yes  No

If you took the child to an emergency room, which one did you go to? \_\_\_\_\_

**PROBLEM HISTORY:**

Child's Age: \_\_\_\_\_ Date of first menstrual period \_\_\_\_\_  N/A **ALLERGIES:** \_\_\_\_\_

Why is your child being seen today? \_\_\_\_\_

When and how did the problem start? \_\_\_\_\_ How long does it last? \_\_\_\_\_ (exp: 1 hour, 1 day)

Where is the problem area? \_\_\_\_\_ Is the problem getting (circle one): same better worse

**Describe any pain the child is having:** Circle level: **Mild** 0 1 2 3 4 5 6 7 8 9 10 **Most Severe (worst)**

Type of pain:  Sharp  Dull  Throbbing

When is it painful? \_\_\_\_\_ What makes it better? \_\_\_\_\_

What makes it worse? \_\_\_\_\_ Any pain at night? \_\_\_\_\_

Symptoms of the problem (check all that apply):  Numbness  Tingling  Bruising  Pain goes somewhere else on body

How have you treated the problem?  Ice  Bracing  Physical Therapy  Chiropractor  Medication: \_\_\_\_\_

**PATIENT MEDICAL HISTORY**

Does your child have a history of the following problems?

Cardiac (heart)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ear, nose or mouth	<input type="checkbox"/> Yes <input type="checkbox"/> No	Eye	<input type="checkbox"/> Yes <input type="checkbox"/> No
Skin rash, sores or bruising	<input type="checkbox"/> Yes <input type="checkbox"/> No	Endocrine (example: diabetes)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric	<input type="checkbox"/> Yes <input type="checkbox"/> No
Stomach or bowel	<input type="checkbox"/> Yes <input type="checkbox"/> No	Immunology	<input type="checkbox"/> Yes <input type="checkbox"/> No	Neurological	<input type="checkbox"/> Yes <input type="checkbox"/> No
Musculoskeletal or arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hematology, bleeding, oncology	<input type="checkbox"/> Yes <input type="checkbox"/> No	Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No
Lung or breathing problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Bladder	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Please explain any "Yes" answers \_\_\_\_\_

Prior surgeries or hospitalizations \_\_\_\_\_

**FAMILY MEDICAL HISTORY**

Arthritis  Yes  No Hypertension  Yes  No Muscular or bone disease  Yes  No

Cancer  Yes  No Diabetes  Yes  No Cardiac (heart) disease  Yes  No

Please explain any "Yes" answers \_\_\_\_\_

**DEVELOPMENTAL AND SOCIAL HISTORY**

Birth:  Full-term  Premature Weeks of pregnancy \_\_\_\_\_ Birth weight: \_\_\_\_\_lb \_\_\_\_\_oz

Vaginal  C-Section  Head First  Feet or Bottom First (Breech) Length of infant hospital stay \_\_\_\_\_

Age at first time: \_\_\_\_\_ Sitting \_\_\_\_\_ Crawling \_\_\_\_\_ Walking \_\_\_\_\_ Words \_\_\_\_\_ Toilet Training \_\_\_\_\_

Right-handed  Left-handed Problems with using hands or fingers \_\_\_\_\_  None

Sports Participation \_\_\_\_\_ Favorite Activities \_\_\_\_\_

School \_\_\_\_\_ Grade \_\_\_\_\_ Usual report cards grades \_\_\_\_\_

**QUESTIONS FOR THE DOCTOR**

1. \_\_\_\_\_

2. \_\_\_\_\_