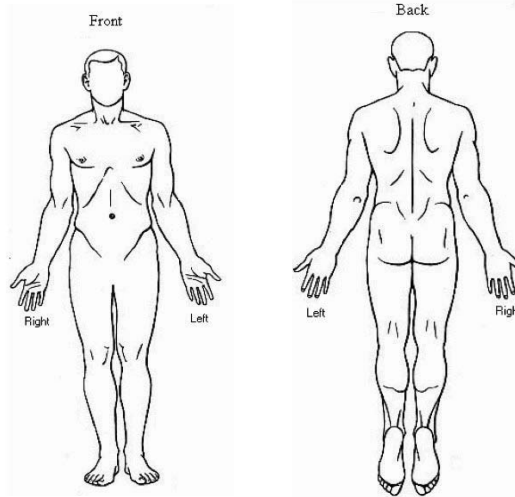


Patient Name: _____ Age: _____ Date: _____

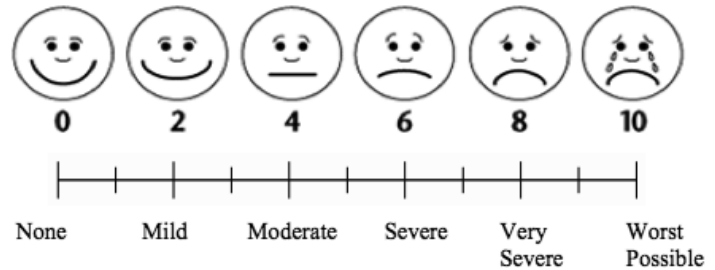
New Patient Pediatric Form

Please complete all questions. All responses will remain confidential.

1. If you are having pain, please mark where your pain is on the diagram below:



2. Please place an X on the hash mark that most accurately describes your pain NOW:



3. How long have you had this pain? _____

4. What makes the pain worse?

Sitting Standing Walking Lying down Nothing _____

5. What makes the pain better?

Sitting Standing Walking Lying down Nothing _____

6. If you have scoliosis/kyphosis, when was it first discovered? (Month/Year) _____

7. Does anyone else in your family have scoliosis or kyphosis? Yes No

If yes, what relation and what type of treatment did they receive? _____

8. What treatments have you tried for this problem? (Check all that apply)

Acupuncture Chiropractic Care Physical Therapy - # sessions _____

Tylenol Anti-inflammatories (Aleve, Motrin, Advil, etc.) Muscle relaxants

Bracing Pain medications (please list) _____



9. Females only: Have you started your periods? Yes No

If yes, when did they begin? (Month/Year) _____

10. Is there anything else that you think we should know about? _____

Medical History

Diabetes Asthma Migraine headaches Anxiety Depression

Cancer(type: _____)

Other: _____

Surgical History

Surgical Procedure	Date	Complication

Medications

Medication	Dose	Frequency

Allergies No known drug allergies _____

Are you allergic to Latex? Yes No

Social History Which school do you attend? _____ Grade? _____

Who do you live with? Mom Dad Siblings Other: _____

How many siblings? _____ Brothers _____ Sisters _____ Pets? _____

Do you smoke? Yes No If yes, how many packs per day? _____

Do you chew tobacco? Yes No Any illicit drugs? Yes No

Do you drink alcohol? Daily 1-2 x/week 1-2 x/month Rarely Never

Family History

Diabetes? Yes No DVT or PE (pulmonary embolus)? Yes No

Heart disease? Yes No Malignant hyperthermia? Yes No

Stroke? Yes No Mental health disorders? Yes No

Cancer? Yes No What type of cancer? _____

Review of Systems

Do you have any current (within the last few weeks) problems with:

Constitutional symptoms

- Good general health Yes No
 Fever Yes No
 Unexplained weight change Yes No

Eyes

- Wear glasses or contacts Yes No
 Change in vision Yes No

Ears, nose, mouth, throat

- Nose bleeds Yes No
 Swallowing difficulty Yes No

Cardiovascular

- Chest pains Yes No
 Swelling of feet or ankles Yes No
 Sudden heartbeat changes Yes No

Respiratory

- Shortness of breath Yes No
 Frequent coughing Yes No
 Asthma or wheezing Yes No

Gastrointestinal

- Nausea or vomiting Yes No
 Change in bowel movements Yes No
 Abdominal pain Yes No

Genitourinary

- Frequent urination Yes No
 Burning or painful urination Yes No
 Blood in urine Yes No
 Urinary incontinence Yes No

Females only:

- Painful periods Yes No
 Irregular periods Yes No

Date of last menstrual period _____

Musculoskeletal

- Joint pain Yes No
 Joint stiffness or swelling Yes No
 Weakness Yes No
 Difficulty walking Yes No
 Muscle pain or cramps Yes No

Integumentary

- Rash or itching Yes No
 Change in skin, hair or nails Yes No

Females only:

- Breast pain or lumps Yes No

Neurological

- Frequent headaches Yes No
 Dizziness Yes No
 Seizures Yes No

Psychiatric

- Depression Yes No
 Anxiety Yes No
 Sleep problems Yes No

Endocrine

- Heat or cold intolerance Yes No
 Excessive thirst or urination Yes No

Hematologic/lymphatic

- Easily bruise or bleed Yes No
 Slow to heal after cuts Yes No
 Swollen glands Yes No

Allergic/immunologic

- Hay fever Yes No
 Recurrent infections Yes No

I attest that the above answers are true and have been completed to the best of my knowledge.

Patient or Parent Signature: _____

Date/Time: _____

I have reviewed the history and review of systems.

Physician Signature: _____

Date/Time: _____