

Patient Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_

**New Patient Pediatric Form**

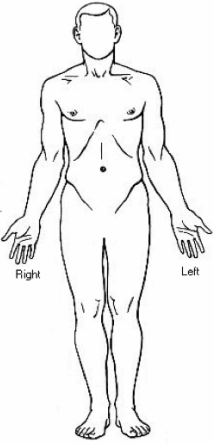
**Please complete all questions. All responses will remain confidential.**

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

Use the body diagrams to show where you feel the following sensations.

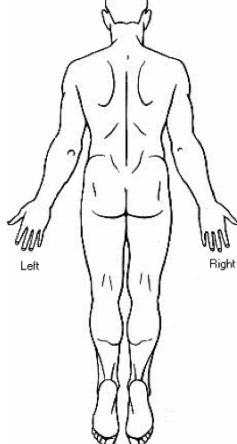
<u>Ache</u>	<u>Numbness</u>	<u>Burning</u>	<u>Stabbing</u>
AAA	000	XXX	///
AAA	000	XXX	///
AAA	000	XXX	///
<u>Pins And Needles</u>			
= = =			

Front



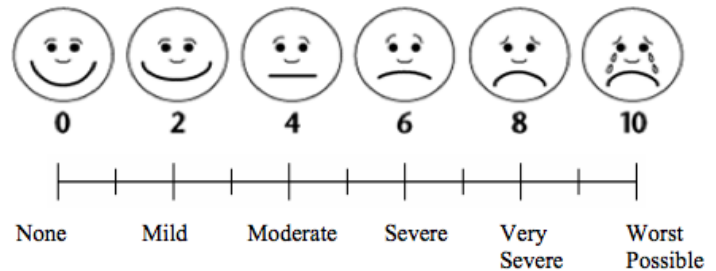
Right      Left

Back



Left      Right

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



0      2      4      6      8      10  
 None      Mild      Moderate      Severe      Very Severe      Worst Possible

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: \_\_\_\_\_