Pediatric Orthopaedic Intake Sheet

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Today's Date_____ Pediatrician/ Primary Care MD_____

Other Physicians or therapists _____

_____

Why is your child being seen today? _____

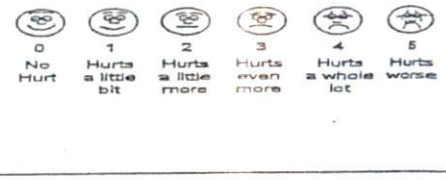
_____

Is the problem getting **worse** **same** **better**? (circle one)

How long has your child had the problem? _____

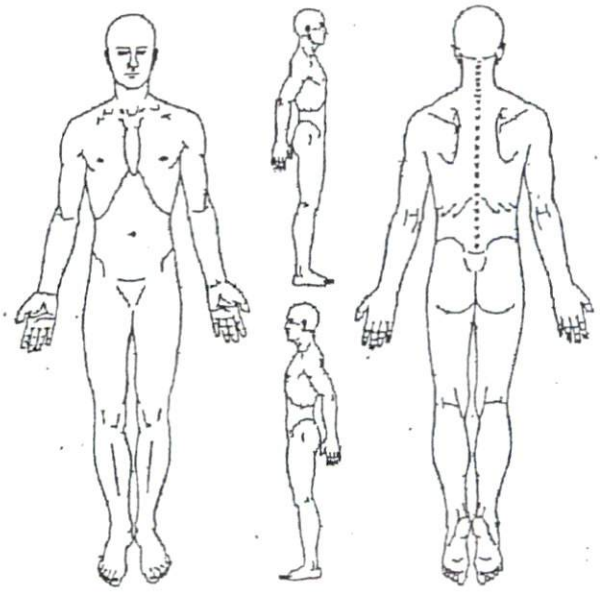
Does your child have pain? **Yes** **No** If yes, describe the pain

How severe is the pain? (circle one)



Numbness	Pins & Needles	Burning	Aching	Stabbing
------	ooooo	^^^^	xxxx	⊗⊗⊗⊗
------	ooooo	^^^^	xxxx	⊗⊗⊗⊗
------	ooooo	^^^^	xxxx	⊗⊗⊗⊗

Mark the diagrams with symbols provided.



What makes the problem worsen?_____

What makes the problem better? _____

Previous xrays or other images (list name, location and date of study) _____

Prior treatments (brace/therapy) _____

Prior Injuries and illness _____

Prior Surgeries _____

Current Medications _____

Allergies (include food) _____ Latex Allergy? Yes or No

Birth History (circle)

Full term or premature Vaginal or C-section Bottom first (breech) or head first

Birth Weight _____ Complications _____

Developmental History

Age of sitting _____ Crawling _____ Walking _____

Age of first word _____ Sentences _____

Problem using hands or fingers _____

Family History

Dad's age _____ Any health problems _____

Mom's age _____Any health problems _____

Brothers and sisters ages and health problems _____

Social History

School _____ Grade _____

Usual report card grade _____ Favorite activities _____

Review of System (check all that apply to your child)

__ Fever
__ Weight loss
__Weight gain
__ Change in appetite
__Diarrhea
__Constipation
__Abdominal pain
__Gastrostomy tube/button
__Chest pain
__Heart problems
__Skin rash
__Skin sores
__Skin lump
__Eczema

__Vision Problems
__Glasses
__Deafness
__Dizziness
__Ringing in ears
__Sinus problems
__Shortness of breath
__Asthma
__Cough
__Tracheostomy
__Behavior problems
__Sleep problems
__Bleeding problem
__Syndrome

__Speaking problems
__Swallowing problems
__Numbness (arms or legs)
__Change in feeling (arms or legs)
__Poor coordination
__Memory problems
__Balance problems
__Wears diapers
__Urine problems
__Menstrual problems
__Pregnancies
__Eating or drinking problem
__Hair change
__Diabetes

Questions for the Doctor/PA _____

_____

Parent/ guardian signature _____ Date_____

Physician Signature _____ Date _____