

New Patient History

For office use only: _____ _____ _____

Please answer all of the questions that you can. If you are unsure or something does not apply, leave it blank.

Patient Information:

Name: _____ Gender: Male Female
Date of Birth: _____ Age: _____

Referral:

Who referred you to us?

Today's Visit:

What is the reason for your visit?

Symptoms:

Which side is affected? Right Left Both N/A

When did this start?

Was there a specific injury or inciting event? Yes (If yes, please describe) No

Severity of pain? (0 = none, 10 = worst) ___/10

Since they started, symptoms are getting: Improving Worsening About the same

What makes the pain better?

What makes the pain worse?

Prior Testing/Treatment:

Tests done? X-rays MRI CT scan
 Other: _____

Prior treatment? Rest Ice Heat
 Medication: _____
 Cast, splint or brace: _____
 Physical therapy: _____
 Surgery: _____
 Other: _____

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Medical History:

Please list medical conditions, past surgeries or hospitalizations.

Medications: List all of your medications.

Include vitamins, supplements, and over-the-counter medications.

Allergies:

Any medication allergies? No Yes: _____

Allergy to latex, metal, or other material? No Yes: _____

Family History:

Any family history of orthopedic conditions?

Scoliosis Yes No

Hip dysplasia Yes No

Clubfoot Yes No

Other: Yes No

Any medical conditions in the family? Yes No

If so, please describe:

Birth History:

Weeks of gestation (Full term?):

Delivery: Vaginal Caesarean

Birth weight:

Any complications? Yes No Please describe:

Developmental History:

Any physical, mental, or speech handicaps? Yes No

Please describe:

At what age did your child: Sit without support?

Walk independently?

Menstrual History (Females only):

Has your daughter had her 1st period? Yes No

If yes, when did they 1st start?

Social History:

Grade level: Pre-K K 1 2 3 4 5 6 7 8 9 10 11 12 College

School Name/Location:

Any alcohol, tobacco, or illegal drug use?

No Yes (If yes, please describe)

Sports or hobbies:

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Review of Systems:

Any of the following medical symptoms? Check all that apply, or "None" for each category.

Constitutional	<input type="checkbox"/> Fevers/Chills <input type="checkbox"/> Fatigue <input type="checkbox"/> Recent cold, flu, or other illness (within last 2 weeks) <input type="checkbox"/> Other:	<input type="checkbox"/> None
Eyes	<input type="checkbox"/> Difficulty seeing <input type="checkbox"/> Temporary loss of vision <input type="checkbox"/> Other:	<input type="checkbox"/> None
Ears, Nose, and Throat	<input type="checkbox"/> Problems with hearing <input type="checkbox"/> Nose bleeds <input type="checkbox"/> Sore throat <input type="checkbox"/> Other:	<input type="checkbox"/> None
Cardiovascular	<input type="checkbox"/> Chest pain <input type="checkbox"/> Racing heartbeat <input type="checkbox"/> Other:	<input type="checkbox"/> None
Respiratory	<input type="checkbox"/> Shortness of breath <input type="checkbox"/> Cough <input type="checkbox"/> Wheezing <input type="checkbox"/> Other:	<input type="checkbox"/> None
Gastrointestinal	<input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Frequent heartburn or indigestion <input type="checkbox"/> Nausea/Vomiting <input type="checkbox"/> Other:	<input type="checkbox"/> None
Genitourinary	<input type="checkbox"/> Blood in urine <input type="checkbox"/> Pain with urination <input type="checkbox"/> Urinary frequency/urgency <input type="checkbox"/> Other:	<input type="checkbox"/> None
Musculoskeletal	<input type="checkbox"/> Joint pain <input type="checkbox"/> Joint swelling <input type="checkbox"/> Other:	<input type="checkbox"/> None
Skin	<input type="checkbox"/> Rashes <input type="checkbox"/> Itching <input type="checkbox"/> Other:	<input type="checkbox"/> None
Neurological	<input type="checkbox"/> Fainting <input type="checkbox"/> Numbness/tingling <input type="checkbox"/> Headache <input type="checkbox"/> Other:	<input type="checkbox"/> None
Psychiatric	<input type="checkbox"/> Depressed mood <input type="checkbox"/> Anxiety <input type="checkbox"/> Other:	<input type="checkbox"/> None
Endocrine	<input type="checkbox"/> Recent weight change > 5 pounds <input type="checkbox"/> Thyroid problems <input type="checkbox"/> Other:	<input type="checkbox"/> None
Hematologic	<input type="checkbox"/> Easy bleeding <input type="checkbox"/> Other:	<input type="checkbox"/> None
Allergic/Immunologic	<input type="checkbox"/> Seasonal allergies <input type="checkbox"/> Frequent infections <input type="checkbox"/> Other:	<input type="checkbox"/> None

To the best of my knowledge, my answers are correct: _____

Signature (Parent/Guardian)

Date

Signature (Provider)

Date