



New Patient History

For office use only: W: _____ H: _____ T: _____ _____ _____
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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:

Sports or hobbies:

Any alcohol, tobacco, or illegal drug use?

No Yes (If yes, please describe)

Dallas Location

7777 Forest Lane, Suite C135
Dallas, TX 75230

McKinney Location

5236 W. University Drive, Suite 2900
McKinney, TX 75071

New Patient History

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