Thank you for taking the time to fill out this intake questionnaire. Please complete the form as much as possible. If you are not comfortable answering a question, we respect your privacy to leave it blank.

PEDIATRIC ORTHOPAEDICS & SPORTS MEDICINE OFFICE VISIT QUESTIONNAIRE

PATIENT NAME: _____ **AGE:** _____ **DOB:** _____

NAME OF PERSON COMPLETING FORM & RELATION TO PATIENT: _____

HOW DID YOU HEAR ABOUT US? _____

REASON FOR TODAY'S VISIT: _____

HOW LONG HAS THIS BEEN A CONCERN? _____

IF YOU ARE HERE BECAUSE OF AN INJURY:

DATE OF INJURY: _____

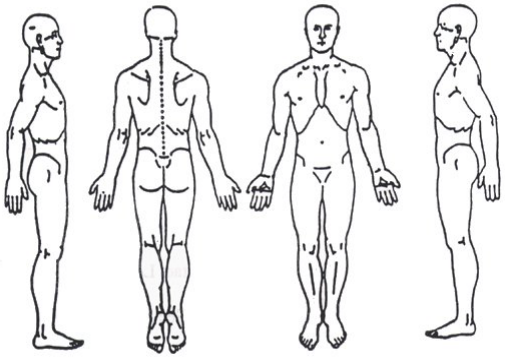
HOW DID INJURY OCCUR (i.e. FALL, COLLISION, SPORTS, ETC): _____

ABLE TO CONTINUE PLAYING? ☐ **YES** ☐ **NO**

ABLE TO USE LIMB OR BEAR WEIGHT? ☐ **YES** ☐ **NO**

HISTORY OF SIMILAR INJURY? ☐ **YES** ☐ **NO** **If yes, explain:** _____

WHERE DOES IT HURT? ***Mark diagram below.***



ARE YOU HAVING ANY SYMPTOMS?

☐ **Pain** ☐ **Redness** ☐ **Swelling** ☐ **Bruising**
☐ **Warmth** ☐ **Cramping** ☐ **Numbness** ☐ **Tingling**
☐ **Weakness** ☐ **Limp** ☐ **Stiffness** ☐ **Popping**
☐ **Locking** ☐ **Catching** ☐ **Instability** ☐ **Fever**
☐ **Chills** ☐ **Rash** ☐ **Pain in other joints**
☐ **Visible deformity**
☐ **Other symptoms:** _____

PREVIOUS WORKUP (i.e. labs, x-rays, other imaging)?

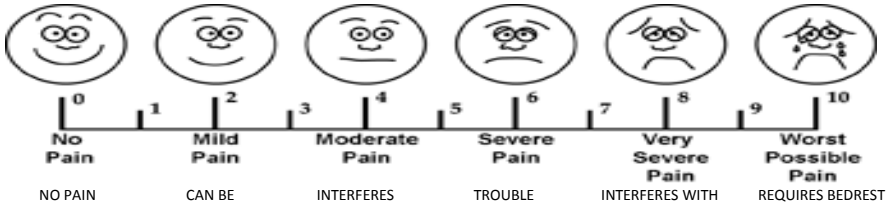
_____

If imaging done, did you bring copies today? ☐ **YES** ☐ **NO**

TREATMENT SO FAR? ☐ **Medicine** ☐ **Ice** ☐ **Heat** ☐ **Rest** ☐ **Physical therapy** ☐ **Taping** ☐ **Orthotics/Brace**
☐ **Other:** _____

ANY OTHER PHYSICIANS INVOLVED IN CARE OF THIS ISSUE? _____
(i.e. orthopaedics, sports medicine, podiatry, neurology, rheumatology, chiropractic)

WHAT MAKES IT WORSE? *Certain activities or movements?*	**WHAT MAKES IT BETTER?** *Ice? Heat? Meds? Resting?*	**WHAT DOES THE PAIN FEEL LIKE?** *Sharp? Stabbing? Aching? Dull? Tight? Pressure?*	**HOW BADLY DOES IT HURT ON A SCALE OF 0-10** *(See chart below)*	**WHEN DOES IT HAPPEN?** • *During or after an activity?* • *Any particular time of day?* • *How long does the pain last?*
			At best: _____ **At the worst:** _____ **Pain at rest? Yes No**	



CONTINUED ON OTHER SIDE → →

ANY OTHER MEDICAL CONDITIONS? ☐ YES ☐ NO

If yes, please specify:

☐ Asthma ☐ Lung issues: _____

☐ ADHD ☐ Heart issues: _____

☐ Allergies ☐ Stomach/GI issues: _____

☐ Neurologic issues: _____

☐ Broken bone(s): _____

☐ Issues with wound healing

☐ Other: _____

FEMALE PATIENTS → Have you started your periods? ☐ YES (Age and/or how long ago: _____) ☐ NO

BIRTH HISTORY:

Delivery timing: ☐ Full term ("born on time" at 37-42 weeks) ☐ Premature (# wks: _____)

Type of delivery: ☐ Vaginal ☐ C-section (reason: _____)

Breech (feet first): ☐ NO ☐ YES

Complications? ☐ NO ☐ YES: _____ ☐ Stayed in NICU

DEVELOPMENTAL HISTORY:

☐ No delay → walked at _____ months

☐ Diagnosed with delay → ☐ motor ☐ speech ☐ other: _____

☐ Therapies or interventions → please circle: CURRENT or IN THE PAST):

☐ Physical therapy (PT) ☐ Occupational therapy (OT)

☐ Speech therapy ☐ Special education classroom

DO YOU TAKE ANY MEDICATIONS?

☐ NO

☐ YES, they are already listed in McLaren's computer system

☐ YES (or any additions/changes): _____

HAVE YOU HAD SURGERY BEFORE? ☐ YES ☐ NO

If yes, please specify:

☐ Tonsillectomy ☐ Adenoidectomy ☐ Ear tubes

☐ Hernia repair ☐ Other: _____

MALE PATIENTS ONLY → **Circumcision as newborn/infant?** ☐ YES ☐ NO

ALLERGIES? ☐ None known ☐ Environmental allergies ☐ Medication allergy

Allergic to: _____ **Reaction that occurs:** _____

FAMILY HISTORY?

☐ Mom takes medication for or has diagnosis of: _____

☐ Dad takes medication for or has diagnosis of: _____

☐ Siblings take medication for or diagnosed with: _____

***Other conditions in family*:**

☐ Diabetes type I ☐ Diabetes type II (adult) ☐ Heart disease

☐ High blood pressure ☐ High cholesterol ☐ Lung disease

☐ Migraines ☐ Cancer: _____

☐ Scoliosis ☐ Juvenile arthritis ☐ Hip dysplasia

☐ Clubfoot ☐ Lupus ☐ Hypermobility

☐ Flat feet ☐ Wound healing issues

☐ Bone, muscle, joint issues during childhood: _____

☐ Neuromuscular disease (muscular dystrophy, etc): _____

☐ OTHER: _____

SOCIAL HISTORY:

GRADE & NAME OF SCHOOL	SPORTS PLAYED? *Please list position(s) if applicable*	INTERESTS or ACTIVITIES? *Dance, art, books, computer, video games?*	ANY CURRENT THERAPY OR ACCOMODATIONS? *PT? OT? Speech? Special education?*	WHO DOES PATIENT LIVE WITH? *Parents? Siblings?*	TOBACCO EXPOSURE AT HOME? *Includes in car, outside, etc.*	RIGHT-HANDED OR LEFT-HANDED?
					☐ YES ☐ NO	

ANYTHING ELSE YOU WOULD LIKE US TO KNOW OR DISCUSS: _____