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 decision to leave it blank.

PEDIATRIC ORTHOPEDICS & SPORTS MEDICINE OFFICE VISIT QUESTIONNAIRE

PATIENT NAME: ______________________ AGE: __________ DOB: ______________

NAME OF PERSON COMPLETING FORM & RELATION TO PATIENT: ______________________

PREFERRED PHONE #: ______________________ HOW DID YOU HEAR ABOUT US? ______________

NAME OF PRIMARY OR REFERRING PHYSICIAN: ______________________ OFFICE LOCATION: __________

REASON FOR TODAY'S VISIT: ______________________

HOW LONG HAS THIS BEEN A CONCERN? ______________________

IF YOU ARE HERE BECAUSE OF AN INJURY:

DATE OF INJURY (or approximate): ______________________

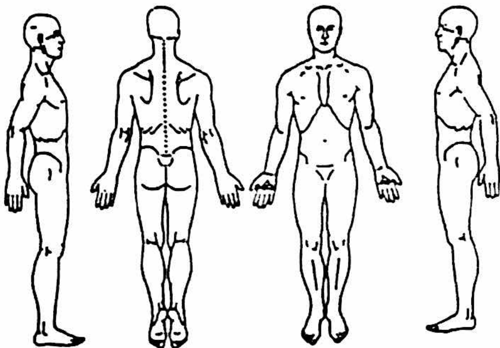
HOW DID INJURY OCCUR (i.e. FALL, COLLISION, OVERUSE, ETC): ______________________

ARE YOU ABLE TO CONTINUE PLAYING? ◯ YES ◯ NO

ARE YOU ABLE TO USE THE LIMB OR BEAR WEIGHT? ◯ YES ◯ NO

ANY HISTORY OF SIMILAR INJURY? ◯ YES ◯ NO *If yes, explain:* ______________

WHERE DOES IT HURT? *Mark diagram below.*



WHAT SYMPTOMS ARE YOU HAVING OR HAVE YOU HAD?

◯ Pain ◯ Redness ◯ Swelling ◯ Bruising
◯ Warmth ◯ Cramping ◯ Numbness ◯ Tingling
◯ Weakness ◯ Limp ◯ Stiffness ◯ Popping
◯ Locking ◯ Catching ◯ Instability ◯ Fever
◯ Chills ◯ Rash ◯ Visible deformity
◯ Other symptoms: ______________

PREVIOUS WORKUP (i.e. blood tests, x-rays, MRI, CT , etc.)?

____

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

Where & when was the imaging done? ______________________

TREATMENT SO FAR?

◯ Medicine (name, dose?) ______________ ◯ Ice ◯ Heat

◯ Physical or occupational therapy (where, when?) ______________

◯ Taping ◯ Stretching ◯ Brace ◯ Massage ◯ Chiropractic

◯ Shoe inserts ◯ Rest (How long?) ______________

◯ Surgery (type, date?): ______________ ◯ Other: __________

WHAT MAKES THIS WORSE? *Certain activities or movements?*	WHAT MAKES IT BETTER? *Ice? Heat? Meds? Resting?*	WHAT DOES THE PAIN FEEL LIKE? *Sharp? Aching? Dull? Tight? Pressure?*	HOW BADLY DOES IT HURT ON A SCALE OF 0-10 0 = no pain at times 3-4 = interferes with tasks 6 = hard to concentrate	WHEN DO YOU HAVE SYMPTOMS?
			At the least: _____ / 10 At the worst: _____ / 10 Pain at rest? Yes No	During activity? Yes No After activity? Yes No Does it wake you from sleep? Yes No Pain first thing in the morning? Yes No

ANY OTHER PHYSICIANS INVOLVED IN CARE OF THIS ISSUE?

____

(i.e. primary provider, orthopedics, sports med, podiatry, neurology, rheumatology, chiropractic)

ANY OTHER MEDICAL CONDITIONS?
If yes, please specify:

◯ Please check here if you would like us to know that the patient is adopted.

◯ NO
◯ Asthma
◯ ADD or ADHD
◯ Seasonal allergies
◯ Depression
◯ Lung issues: ____________
◯ Cardiac issues: ____________
◯ Stomach/GI issues: ____________
◯ Anxiety
◯ Neurologic issues: ____________
◯ Orthopedic issues, including broken bone(s): ____________
◯ Issues with wound healing ◯ Nutritional issues: ____________
◯ Other: ____________

FEMALE PATIENTS ONLY → Have you started your periods? ◯ YES (Age or month/year of start: ____________) ◯ 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 delays *Walked at* ________ *months*
◯ Diagnosed with delay → ◯ Motor ◯ Speech ◯ Other: ____________
Therapies or interventions: ◯ Physical therapy: *If yes, CURRENTLY or IN PAST? (please circle)*
◯ Occupational therapy : *If yes, CURRENTLY or IN PAST? (please circle)*
◯ Speech therapy: *If yes, CURRENTLY or IN PAST? (please circle)*

DO YOU TAKE ANY MEDICATIONS? ◯ NO ◯ YES (name & dose): ____________
Check here ◯ *if they are already listed in HDVCH/Spectrum's system from another visit.*

HAVE YOU HAD SURGERY BEFORE? ◯ NO ◯ YES (type & date): ____________
MALE PATIENTS ONLY → Circumcision as infant? (considered surgery in medical record) ◯ *YES* ◯ *NO*

ALLERGIES? ◯ None known ◯ Environmental allergies ◯ Medication allergy
Allergic to: ____________ Reaction that occurs: ____________

FAMILY HISTORY? Mom takes medication for or has diagnosis of: ____________ ◯ None ◯ Unknown
Dad takes medication for or has diagnosis of: ____________ ◯ None ◯ Unknown
Siblings take medication for or diagnosed with: ____________ ◯ None

Other conditions in family:
◯ Diabetes type I ◯ Diabetes type II (adult) ◯ Heart disease ◯ High blood pressure
◯ High cholesterol ◯ Lung disease ◯ Migraines ◯ Wound healing issues
◯ Cancer: ____________
◯ Scoliosis ◯ Juvenile arthritis ◯ Hip dysplasia ◯ Clubfoot
◯ Lupus ◯ Hypermobility ◯ Flat feet
◯ OTHER: ____________

SOCIAL HISTORY:

GRADE & NAME OF SCHOOL	ACTIVITIES & SPORTS PLAYED? (Includes DANCE) *Please list position(s) if applicable*	ANY CURRENT THERAPY OR SCHOOL ACCOMODATIONS? *PT? OT? IEP? Special education?*	WHO DOES PATIENT LIVE WITH? *Parent? Guardian?*	TOBACCO EXPOSURE AT HOME? *Includes in car, outside, etc.*	RIGHT OR LEFT-HANDED?
				◯ YES ◯ NO	

WOULD YOU LIKE US TO SEND A COPY OF TODAY'S NOTE TO YOUR PHYSICIAN OR OTHER PROVIDER? ◯ YES ◯ NO
Name of provider: ____________ *Office location (city):* ____________

DO WE HAVE YOUR PERMISSION TO LEAVE RESULTS OR RECOMMENDATIONS ON VOICEMAIL?
◯ NO
◯ YES → Name of contact: ____________ Relation to patient: ____________ Phone #: ____________