



SOUTHWEST SCOLIOSIS INSTITUTE

Dallas 972-985-2797 · Fort Worth 817-922-2880 · Miami 786-525-1907

PEDIATRIC PATIENT MEDICAL HISTORY

The completion of this form is important to ensure the quality and accuracy of your care. This information is personal and confidential.

DATE: _____ PATIENT NAME: _____

DATE OF BIRTH: _____ HEIGHT: _____ WEIGHT: _____

CURRENT COMPLAINT: _____

DURATION: _____ DATE INITIAL DIAGNOSIS GIVEN: _____

CHIEF COMPLAINT: _____

MEDICAL PROBLEMS: Include all hospitalizations or any conditions minor and /or major.

- _____
- _____
- _____

ALLERGIES: Please be sure to list any life-threatening allergies including X-RAY dye, Shellfish, Iodine adhesive tape, antibiotics or metals.

- _____
- _____
- _____

SURGERIES:

YEAR	PROCEDURE	SURGEON	LOCATION/HOSPITAL
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- _____
- _____
- _____
- _____
- _____

ANESTHESIA COMPLICATIONS: Have you had any complications or reactions with anesthesia or anything associated with surgery? If yes, please explain.

- _____
- _____
- _____
- _____

PATIENT NAME: _____ DATE: _____

MY PAIN IS: Please check all that apply

Aching	Sharp	Penetrating	Throbbing	Tender	Electric
Nagging	Shooting	Burning	Numb	Stabbing	Constant
Exhausting	Miserable	Gnawing	Tiring	Unbearable	

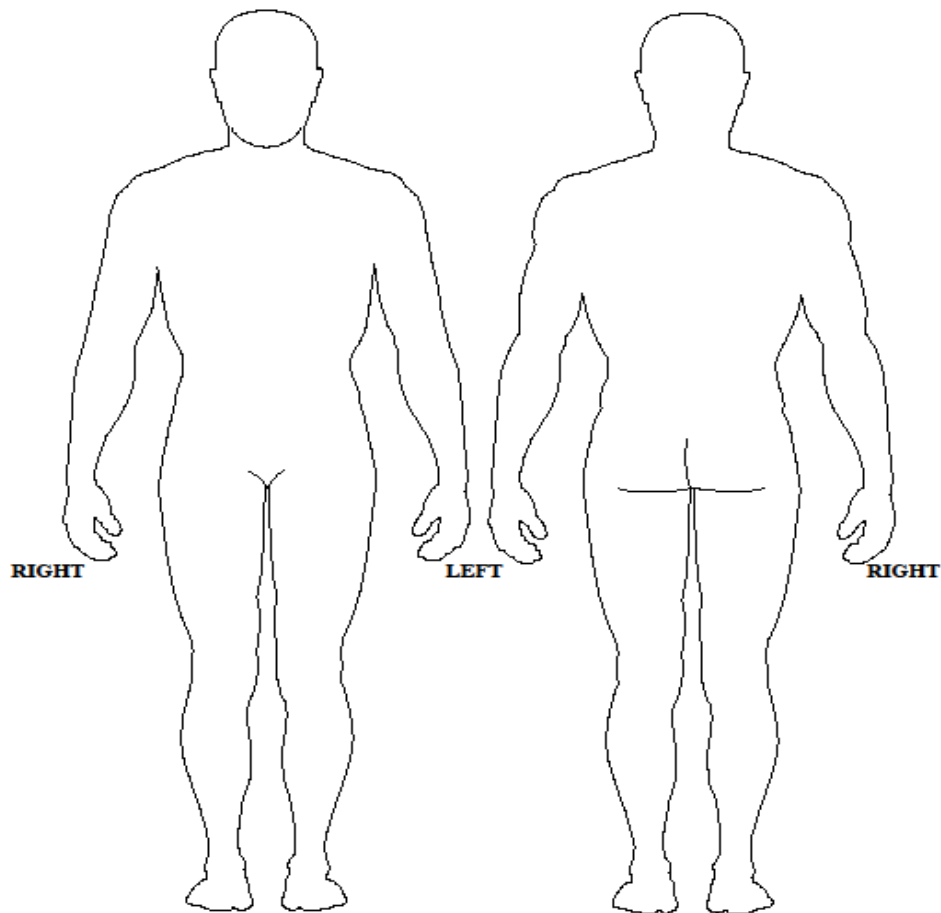
MY PAIN IS WORSE WITH:

Walking	Standing	Sitting	Bending	Working	Physical Activity
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My Pain is made better by: _____

Pain Drawing

Please mark below on the pain drawing where/ if you experience pain (XXX), tingling (000) or numbness (III)



PATIENT NAME: _____ DATE: _____

MEDICATION: Please list name, dose, times per day and prescribing physician.

- _____
- _____
- _____
- _____

TREATMENT HISTORY:

YES / NO Have you tried bracing?
If yes, what type, when and for how long? _____

YES/NO Have you tried physical therapy or core strengthening program, such as Pilates?
If yes, when was your last treatment session: _____

YES /NO Have you tried injections?
If yes, what types of injections/levels? Facet: _____ ESI: _____ Rhizotomies: _____
If yes, who performed the injections? _____ Phone: _____

OTHER: Please check all that apply.

Chiropractic Care Heat Ice Massage Home exercise program

Other: _____

FAMILY HISTORY: This pertains to member of your family (blood related) ie: mother, father, grandparents.

YES/ NO Heart Attack	YES / NO Diabetes
YES / NO Heart Disease	YES / NO Hypertension
YES / NO Bleeding Problems	YES / NO Tuberculosis
YES / NO Blood Clots	YES / NO Scoliosis
YES / NO Stroke	

REVIEW OF PERSONAL HISTORY/ SYSTEMS: This pertains only to you, the patient.

YES / NO Chest Pain	YES / NO Hypertension
YES / NO Gastrointestinal Issues	YES / NO Heart Failure
YES / NO Lung/ Pulmonary Issues	YES / NO Endocrine Problems
YES / NO Stroke	YES / NO Stress Test, Heart Cath
YES / NO Urinary Issues	YES / NO Swelling in the legs
YES / NO Frequent Infections	YES / NO Hepatitis
YES / NO Possibility of Pregnancy	Last Normal Period _____ Days of cycle _____
YES / NO Pain in Legs	YES / NO Weakness in Legs / Arms
YES / NO Numbness in Leg/ Arms	YES / NO Have you lost or gained weight recently

YES / NO Excessive bleeding with surgery, nose bleeds, bruise easily

PATIENT NAME: _____ DATE: _____

SOCIAL HISTORY:

CURRENT SCHOOL AND GRADE: _____

CURRENT SPORTS PARTICIPATION: _____

HOBBIES: _____

PEDIATRIC QUESTIONNAIRE: Complete if the patient is under 21 years of age

YES / NO Normal pregnancy and delivery? If no, describe _____

YES / NO Was your child in the breech position at any time during pregnancy _____

YES / NO Normal Developmental milestones
(sitting, walking, standing) If no, describe _____

YES / NO Has your child previously seen a pediatric orthopedist, neurologist, neurosurgeon, or other
Developmental specialist? If yes, please give name/ type: _____

YES / NO Has your child been given a neurosurgical or orthopedic diagnosis?
If yes, describe: _____

YES / NO Is your current visit the result of a school screening. If yes, please give the name of the
School _____

YES / NO Are your child's immunization up to date

YES / NO Is there a family history of joint, limb, or bone problems.
If yes, describe _____

YES / No For female patients: Have you started your menstrual period?
If yes, date of first period. _____

ADDITIONAL COMMENTS: Please include any important information that was not covered in the above section that you feel will be important or pertinent to your care:

My signature below confirms that all information given is true and correct to the best of my knowledge.

Name of person completing form if other than patient: _____

Relation to the patient: _____

Name of legal guardian/ parent if other than above: _____

Signature of person completing forms: _____

Date: _____