Providence Pediatric Orthopedics
In Collaboration with
Shriners Hospital for Children

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Patient Name: ______________________________ DOB: ______________
Last First Middle month day year

Referred By: ☐ Self ☐ Urgent Care/Emergency Room ☐ Family ☐ Doctor ______________

Primary Care Physician: ______________________ Ph #: ______________

Primary reason for this appointment: ______________________________

Briefly describe your present symptoms: ______________________________

Approximate date symptoms began: ______________________________

Is this problem due to an injury? ☐ Yes ☐ No If yes, date of Injury: ______________

Is the injury _____ sports related? _____ motor vehicle related?

_____ other (explain)? ______________________

Have you had any previous problems with the same area? ☐ Yes ☐ No

Previous treatments for this problem have included: ☐ None

- ☐ Physical Therapy or Exercise
- ☐ Pain medication
- ☐ Anti-inflammatory medication
- ☐ Manipulation/Chiropractic
- ☐ Bracing
- ☐ Casting
- ☐ Other ______________

Previous tests done to evaluate this problem have included: ☐ None

	Where was test performed?		Where was test performed?
☐ X-ray	______________	☐ CT	______________
☐ EMG/NCV	______________	☐ Bone Scan	______________
☐ MRI	______________	☐ Other	______________

Previous doctors seen for this problem: ☐ None

Doctor	Specialty	Date	Treatment
______________	______________	______________	______________
______________	______________	______________	______________

Developmental History:

Born ☐ full term ☐ premature at ________ weeks by ☐ vaginal ☐ C-section delivery

Complications during pregnancy or delivery: ______________________________

Began walking: ☐ on time ☐ delayed ______________________________

Began speaking: ☐ on time ☐ delayed ______________________________

Other Medical History: ☐ None

Problem	Followed by	Treatment

Prior Surgeries: ☐ None

Date	Type of Surgery

Current Medications (include prescription and over-the-counter): ☐ None

Name	Indication

Allergies: ☐ No known allergies

Name	Type of Reaction

Have you recently had any of these symptoms (check all that apply)?

☐ Fevers/chills	☐ Chest pain	☐ Frequent or painful urination
☐ Unexplained weight loss/gain	☐ Difficulty breathing	☐ Joint pain/extremity pain
☐ Vision changes	☐ Nausea/vomiting/abdominal pain	☐ Skin rash/lesions
☐ Headache, dizziness, weakness	☐ Constipation/diarrhea	☐ Depression/suicidal thoughts

Lives with: ______________________________

Tobacco use: ☐ none ☐ patient ☐ in home environment ______________________

Drug use: ☐ none ☐ patient ☐ in home environment ______________________

Any concerns for environmental exposures: ☐ no ☐ yes ______________________

Any concerns for abuse: ☐ no ☐ yes ______________________

Patient/Guardian Signature: ______________________ Date: __________