

## Pediatric Orthopedic Evaluation

**Name:** \_\_\_\_\_  
**Date of Birth:** \_\_\_\_\_ **Age:** \_\_\_\_\_  
**Height:** \_\_\_\_\_ **Weight:** \_\_\_\_\_ lbs  
 Right handed Left handed

### **REFERRAL INFORMATION**

Has this patient seen a physician at Front Range Orthopaedics within the past 3yrs?  
 Yes  No

If yes, for this problem?  Yes  No  
 Another problem?  Yes  No  
 If yes, describe \_\_\_\_\_

Has this patient seen another physician, chiropractor or podiatrist for this problem?  
 Yes  No

Who is your **PRIMARY CARE PHYSICIAN?**

Does your primary care physician know about this problem?  Yes  No

Who referred this patient to our office?

Is this a second opinion?  Yes  No  
 If you went to the Emergency Room, which one did you go to? \_\_\_\_\_

Date you were evaluated \_\_\_\_\_

### **CHIEF COMPLAINT/ PRESENT ILLNESS:**

problem/injury \_\_\_\_\_  
 When did the problem/injury start? \_\_\_\_\_

How did the injury happen? \_\_\_\_\_

**Pain severity:**  Mild  Moderate  Severe

**Type of pain:**  Sharp  Dull  Throbbing

**Duration (how long pain lasts):** \_\_\_\_\_

**When is it painful?** \_\_\_\_\_

**What makes it better?** \_\_\_\_\_

**What makes worse?** \_\_\_\_\_

**Do you have any of the following?**  Bruising

Numbness  Tingling and burning  Swelling

Redness

**Does pain wake the patient up at night?**  Yes  No

**Is there morning pain and stiffness?**  Yes  No

**Medicines taken for this problem:**

Tylenol  Ibuprofen

Other: \_\_\_\_\_

**Have you had any of the following diagnostic tests to the area of concern in the last 6-12 months?**

X-rays/ date: \_\_\_\_\_  MRI/ date: \_\_\_\_\_

CT scan/ date: \_\_\_\_\_

Other studies: \_\_\_\_\_ date: \_\_\_\_\_

Location of testing: \_\_\_\_\_

### **Chronic Medical Conditions:**

#### **Musculoskeletal:**

Spina Bifida/Mobility Impairment	yes	no
Muscular Dystrophy	yes	no
Auto-Immune Disorder	yes	no

#### **Neurological:**

Stroke / Mini Stroke	yes	no
Epilepsy	yes	no
Hydrocephalus / Shunt	yes	no
Cerebral Palsy	yes	no

#### **Cardiac:**

Heart Problems / Heart Murmur	yes	no
High Blood Pressure	yes	no
Irregular Heartbeats	yes	no

#### **Pulmonary:**

Asthma	yes	no
Pneumonia	yes	no
Oxygen Use	yes	no
Tuberculosis	yes	no
RSV	yes	no

#### **GI:**

GERD / reflux	yes	no
Hepatitis	yes	no
Liver Disease	yes	no
Jaundice	yes	no

#### **Hem/Oncology:**

Bleeding Disorder	yes	no
Anemia	yes	no
Cancer	yes	no
AIDS / HIV	yes	no

#### **Endocrine:**

Diabetes	yes	no
Metabolic Disorders	yes	no

#### **GU:**

Kidney Disease	yes	no
Bladder Infections	yes	no

#### **Psych:**

Behavioral Problems	yes	no
Developmental Delays	yes	no
Hearing or Speech Problems	yes	no
MRSA	yes	no

**Please Complete Both Sides**



