OSTEOPATHIC HEALTHCARE OF MAINE
PEDIATRIC HISTORY

NAME:_____ DATE:_____

DOB:_____ AGE:_____ M/F:_____

PARENT'S NAMES: MOTHER:_____ FATHER:_____

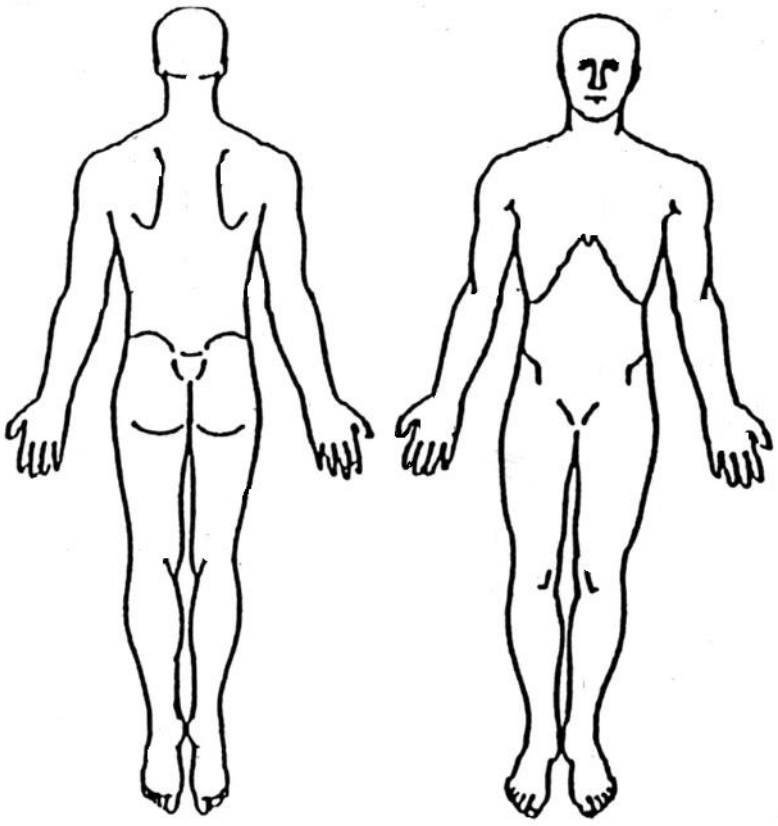
CURRENT STATUS

PRIMARY PROBLEMS

1._____ 3._____
2._____ 4._____

SYMPTOM DRAWING Please mark ALL Areas on Diagrams where you feel these Symptoms:

ACHE	SHARP	NUMB	BURNING	PRESSURE	TIGHT/STIFF	TINGLING
~~	>>>>	oooo	xxxx	++++	/////	****
~~	>>>>	oooo	xxxx	++++	/////	****



How bad is your pain on an average day?

None_____Worst

0 1 2 3 4 5 6 7 8 9 10

Problem	Location	Date of onset	Was the onset Sudden?	Gradual?
1.				
2.				
3.				
4.				

	Occurs how often and for how long?	At what times of day and with what activities, is it Worse?	Better?
1.			
2.			
3.			
4.			

Causes: Birth injury ___ Sport injury ___ MVA ___ Other trauma___ Allergy___
Infection___ Unknown___ Other_____

Please describe these causes:_____
_____
_____
_____

Are you getting: Better ____ Worse ____ No change ____ Unsure ____

PRIOR TREATMENT

NONE:___

Healthcare Provider	Dates	Diagnosis	Treatment Plan
1.			
2.			
3.			

	Better	Worse	No Change		Better	Worse	No Change
Heat/Ice:	____	____	____	Braces:	____	____	____
Rest/Activity:	____	____	____	Orthotics/Lifts:	____	____	____
Stretching:	____	____	____	Surgery:	____	____	____
Strengthening:	____	____	____	Acupuncture:	____	____	____
Massage:	____	____	____	Counseling:	____	____	____
PT/OT:	____	____	____	Other:	____	____	____

	Better	Worse	No Change		Better	Worse	No Change
Manipulation				**Medications**			
Osteopathic:	____	____	____	Anti-Inflammatory:	____	____	____
Chiropractic:	____	____	____	Antibiotic:	____	____	____
Other:	____	____	____	Other:	____	____	____

DIAGNOSTIC TESTS NONE:___

	Dates	Body Area	Results
X-Ray:	_____	_____	_____
CAT Scan:	_____	_____	_____
MRI:	_____	_____	_____
Labs:	_____	_____	_____
Other:	_____	_____	_____
Other:	_____	_____	_____

PAST MEDICAL HISTORY

BIRTH HISTORY

1. Number of months: _____
2. Prenatal problems: _____
3. Duration of labor: _____
4. Duration of pushing:_____
5. Delivery type: _____
6. Procedures used: _____
7. Complications: _____
8. Infant's condition: _____

TRAUMA (Please give details and approximate dates) NONE:___

1. Head trauma/concussion: _____
2. Motor vehicle accidents: _____
3. Injuries (sports, falls, etc.):_____
4. Dental work (extractions, braces):_____
5. Emotional trauma: _____
6. Other: _____

ILLNESS/DISEASE PROCESS (Please give details and dates) NONE:___

1. Arthritis: _____
2. Scoliosis: _____
3. Short leg: _____
4. Seizures: _____
5. Fatigue: _____
6. Feeding problems:_____
7. Colic/Reflux:_____
8. Change in bowel habits: _____
9. Lyme Disease: _____
10. ADD/ADHD: _____
11. Sensory Integration problems: _____
12. Discipline problems: _____
13. Depression/ Anxiety: _____
14. Autistic Spectrum Disorder: _____
15. Eating disorder: _____
16. Obesity: _____
17. Substance abuse: _____
18. Other:_____

SURGICAL HISTORY **NONE:___**

Sinus___ Ear___ Tonsils/Adenoids___ Appendix___ Fracture repair___ Torn cartilage___
Ligament/tendon repair___ Dental___ Circumcision___ Other_____

HOSPITALIZATIONS **NONE:___**

	Hospital	Dates	Diagnosis	Treatment
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____

MEDICATIONS **NONE:___**

Please list all medications including dose and number of times taken per day. Include prescriptions, vitamins, supplements, remedies, etc:

_____ _____ _____
_____ _____ _____

ALLERGIES/SENSITIVITIES **NONE:___**

Please list any reactions to medications, foods, the environment, or chemicals:

_____
_____

SOCIAL HISTORY

HOME ENVIRONMENT

With whom does the child live?:_____
Environmental exposures (including smokers, pets):_____NONE:___
Quality of home life:_____

DEVELOPMENTAL HISTORY

Milestones (fine/gross motor skills, language etc):_____
Academic/Athletic preformance:_____
Social skills (w/peers, w/adults):_____

HABITS

	Amount	Frequency	# Years	When quit	Never
Smoking:	_____	_____	_____	_____	_____
Alcohol:	_____	_____	_____	_____	_____
Drugs:	_____	_____	_____	_____	_____
Caffeine:	_____	_____	_____	_____	_____

HEALTH MAINTENANCE

Physical activity: sports/ recreational (type/frequency):_____NONE:___
Safety measures (seat belts, helmets):_____NONE:___
Stretching (type/frequency):_____NONE:___
Hobbies: performing/visual arts, games, crafts, etc. (type/frequency):_____NONE:___
Nutrition (breast-feeding, protein/veggies/carbs/fruits/snacks/sugar):_____
_____
Fluid intake (type, amount/day):_____
Sleep/Rest (hours/day, quality):_____ _____
Immunizations: _____NONE:___

FAMILY HISTORY

	Age	Health status	Death/cause/age
Father:	_____	_____	_____
Mother:	_____	_____	_____
Siblings:	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

If there are any relatives with problems similar to the child's "Primary Problems", please identify them and the problems: NONE:___
_____
_____

HEALTH PROBLEMS (in any blood relative) NONE:___

Arthritis___ Chronic muscle pain___ Ruptured discs___ Back or joint surgery___ Scoliosis___ Frequent headache___ Migraine___ Fibromyalgia____ CFIDS___ Immune disorders___
Thyroid disease___ Depression___ Anxiety___ Mental illness___ ADHD___ Lyme Disease___
Eating disorder___ Obesity___ Substance abuse___ Other_____

OTHER INFORMATION NONE:___

Is there anything else you would like to share?:
_____
_____
_____

REVIEW OF SYSTEMS NONE:___

Please Check and Circle ALL that apply

General
( ) Weight gain or loss, change in appetite/thirst
( ) Fatigue, weakness,
( ) Change in sleep pattern
( ) Fever, chills, night sweats, cold intolerance
( ) Change in quality of hair/skin, easy bruising
( ) Irritability or indifference

Head, eyes, ears, nose and throat
( ) Eye pain/disease, visual problems
( ) Ear pain/infections/ringing, hearing problems
( ) Chronic sinusitis, nasal discharge
( ) Sore throat, change in voice
( ) Difficulty swallowing

Skin
( ) Itching, burning, rashes (psoriasis, eczema, etc)
( ) Lumps, tumors, cancer
( ) Changes in moles/warts/lesions

Cardiovascular
( ) Chest pain
( ) Palpitations, arrhythmia, heart murmurs
( ) Blood vessel disease, clots, thrombophlebitis
( ) Foot/Ankle swelling
( ) High blood pressure

Respiratory
( ) Wheeze, asthma, use of inhalers
( ) Shortness of breath – with activity/at rest
( ) Frequent cough, bronchitis
( ) Pneumonia, flu
( ) RSV

Gastrointestinal
( ) Nausea/Vomiting
( ) Heartburn, reflux, hiatal hernia
( ) Abdominal pain, ulcer
( ) Change in bowel habits: diarrhea, constipation
( ) Dark tarry stools, blood in stools
( ) Irritable bowel synd., excessive gas, food intol.
( ) Inflammatory Bowl Disease: Crohn's, Ulc. Colitis

Urinary
( ) Kidney stones, tumors
( ) Frequent UTI, pain w/urinating
( ) Enuresis
( ) Sexually transmitted diseases

Nervous System
( ) Seizures, tremors
( ) Headache, head injury
( ) Numbness, tingling
( ) Loss of coordination
( ) Dizziness/Vertigo
( ) Poor memory or concentration
( ) Fainting
( ) Change in taste, smell
( ) Neurologic disease

Musculoskeletal system
( ) Joint pain, redness, swelling, stiffness
( ) Frequent/severe muscle pain/weakness
( ) Disc herniation
( ) Short leg syndrome
( ) Abnormal curvature of the spine

Psychological
( ) Often nervous/worried
( ) Post traumatic stress
( ) Often feeling sad or hopelessness
( ) Hospitalized for mental illness
( ) Psych. diagnosis (i.e., OCD, Manic Depression)

FEMALE Endocrine/Reproductive
( ) Menstrual irregularity: flow, bloating, PMS
( ) Decreased sense of well-being, decreased energy
( ) Decreased mental sharpness/indecisiveness
( ) Delayed or precocious puberty

MALE Endocrine/Reproductive
( ) Decreased sense of well-being, decreased energy
( ) Decreased mental sharpness/indecisiveness
( ) Loss of muscle mass, strength
( ) Delayed or precocious puberty

Other Problems (not listed above):_____
_____ **NONE:___**

History Reviewed (Date and Initial) 1._____ 2._____ 3._____
***Osteopathic Principles and Practice Discussed*: ___**