

OSTEOPATHIC HEALTHCARE OF MAINE
PEDIATRIC HISTORY

NAME: _____

DATE: _____

DOB: _____

AGE: _____

M/F: _____

PARENT'S NAMES: MOTHER: _____ FATHER: _____

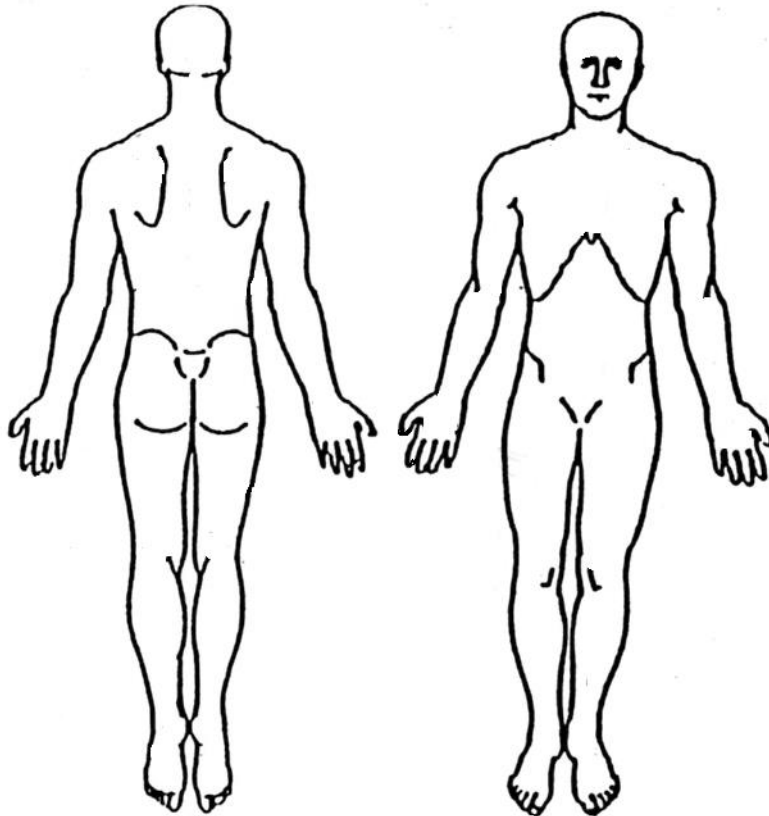
CURRENT STATUS

PRIMARY PROBLEMS

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

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

<u>ACHE</u>	<u>SHARP</u>	<u>NUMB</u>	<u>BURNING</u>	<u>PRESSURE</u>	<u>TIGHT/STIFF</u>	<u>TINGLING</u>
~~~~	>>>>	0000	XXXX	++++	////	****
~~~~	>>>>	0000	XXXX	++++	////	****



How bad is your pain on an average day?
None _____ Worst
0 1 2 3 4 5 6 7 8 9 10

<u>Problem</u>	<u>Location</u>	<u>Date of onset</u>	<u>Was the onset</u> <u>Sudden? Gradual?</u>	
1. _____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____
4. _____	_____	_____	_____	_____

<u>Occurs how often</u> <u>and for how long?</u>	<u>At what times of day and with what activities, is it</u> <u>Worse? Better?</u>	
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:** _____

<u>Healthcare Provider</u>	<u>Dates</u>	<u>Diagnosis</u>	<u>Treatment Plan</u>
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____

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

<u>Manipulation</u>	<u>Better</u>	<u>Worse</u>	<u>No Change</u>	<u>Medications</u>	<u>Better</u>	<u>Worse</u>	<u>No Change</u>
Osteopathic:	___	___	___	Anti-Inflammatory:	___	___	___
Chiropractic:	___	___	___	Antibiotic:	___	___	___
Other:	___	___	___	Other:	___	___	___

DIAGNOSTIC TESTS

NONE: _____

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

SURGICAL HISTORY

NONE: _____

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

HOSPITALIZATIONS

NONE: _____

	<u>Hospital</u>	<u>Dates</u>	<u>Diagnosis</u>	<u>Treatment</u>
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 performance: _____

Social skills (w/peers, w/adults): _____

HABITS

	<u>Amount</u>	<u>Frequency</u>	<u># Years</u>	<u>When quit</u>	<u>Never</u>
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

	<u>Age</u>	<u>Health status</u>	<u>Death/cause/age</u>
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: _____