Highlands Integrative Pediatrics

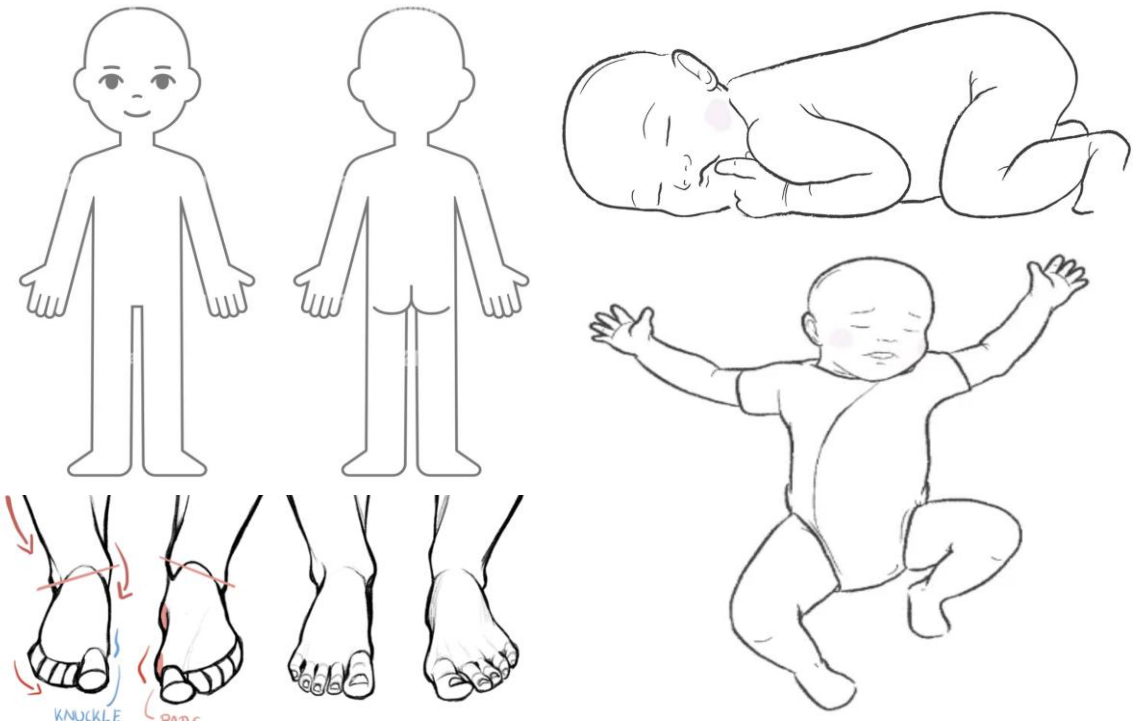
Osteopathic Consultation Form

Child's Name:_____. Parent/Guardian Names:_____
Age: _____ Height: _____ Weight: _____
Pediatrician:

CURRENT STATUS

Primary Problems
What would you like to have evaluated and treated today?_____
_____
If it applies, please draw in the pictures below where this has bothered you or your child

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



How intense are symptoms?

None _____ Worst
0 1 2 3 4 5 6 7 8 9 10

When did this concern start? _____
What caused it to start?
_____

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What else was happening in your family around this time?

_____

_____

Other information you'd like to share about this: _____

_____

Does anything worry you about this concern?_____

What helps it feel better? _____

What makes it feel worse? _____

What helps you feel the best/happiest? _____

What triggers you to feel your worst? _____

Have you had these symptoms before? YES or NO

If yes, when? What happened? _____

_____

_____

Have you seen other care providers for this? YES or NO

Who? _____

When? _____

What was done? _____

Did it help? _____

What are your treatment goals?_____

<u>TRAUMA</u> (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: _____

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REVIEW OF SYSTEMS: Please check all that apply

NONE: ___

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
( ) Bedwetting
( ) 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 hopeless
( ) 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

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Is there anything else you wish to share? _____
_____

Signed:_____Date:_____