SAINT PETER'S
SPORTS MEDICINE INSTITUTE
A MEMBER OF SAINT PETER'S HEALTHCARE SYSTEM

562 Easton Avenue
Somerset, NJ 08873
732.565.5455

PATIENT LABEL

Pediatric Intake Form

Name of child (printed): _____ Age: _____ Child DOB: _____

Name of parent/guardian filling out form (printed): _____ Relationship to child _____

Today's date _____

Describe the problem(s) for which you are seeing the physician today: _____

Which side of the body is injured/hurting? (circle one) **RIGHT** **LEFT** **N/A** **Body part**_____

Is the problem getting: ❑ Better ❑ Same ❑ Worse (please explain) _____

How did the problem begin? _____

When did the problem begin? _____

What makes the problem better? _____

What makes the problem worse? _____

Is there pain? **Yes** **No** (If no, skip next 2 questions)

For the next 2 questions: (younger patients: parents please refer to the faces below, older patients please rate you pain on a scale of 0-10)

0 1 2 3 4 5 6 7 8 9 10

No pain — Moderate pain — Worst pain imaginable

0	1 2	3 4	5 6	7 8 9	10
No Pain	Mild Pain Annoying	Nagging Pain Uncomfortable Troublesome	Miserable Distressing	Intense Dreadful Unbearable	Worst Pain Possible Horrible

What was the level of pain when it first started: 0 1 2 3 4 5 6 7 8 9 10

And what is the level of pain now: 0 1 2 3 4 5 6 7 8 9 10

Have you seen any other physicians/clinicians for this problem? (If yes, please explain)

_____

_____

Have you taken any medications for the pain? (If yes, please list)

_____

For this problem, please list any studies ordered:

-X-rays: area of body _____ date_____ location _____

-CT Scan: area of body _____ date_____ location _____

-MRI Scan: area of body _____ date_____ location _____

-Blood work: date_____ location_____

-Bone Scan: area of body _____ date_____ location _____

Patient Medical History - *Does your child have:*	**Yes**	**No**	**Comments**
1. Congenital heart defects and/or murmurs			
2. Seizures			
3. Congenital anomalies			
4. Meningitis			
5. BPD (bronchopulmonary dysplasia)			
6. Neurologic deficits			
7. ROP (retinopathy of prematurity)			
8. Down Syndrome			
9. Asthma/other			
10. Cancer/blood disorders/anemia			
11. Diabetes			
12. Rheumatoid arthritis			
13. Prematurity			
14. History of special education			
15. Thyroid problems			
16. Scoliosis/spinal problems			
17. Neuromuscular disorders (Cerebral Palsy/spina bifida/other muscle or bone disorders)			
18. Learning disorders (ADHD, dyslexia, etc.)			
19. Sleep Apnea/Snoring/Pneumonia			
20. Gastric reflux/GERD			

Allergy History:

Drug allergies: ❑ None Known ❑ Yes (Please list your child's allergies and the reaction)_____

_____

Latex Allergies: ❑ Yes ❑ No (If yes, what is the reaction) _____

Medications:

List any medications you are currently taking (prescription, over the counter, and vitamins): _____

_____

_____

Past Surgeries: Please list all surgeries and what year surgery was performed): _____

_____

Prior Hospitalizations: ❑ Yes ❑ No (If yes, what was the reason for the hospitalization and what year): _____

_____

Family History: *Has anyone in your immediate family ever been treated for any of the following:*	**Yes**	**No**	**Relative**
1. Diabetes			
2. Heart disease			
3. High blood pressure			
4. Cancer			
5. Osteoporosis or metabolic bone disease			
6. Rheumatoid arthritis/Lupus/ other inflammatory disorders			
7. Mental illness			
8. Bleeding disorders			
9. Neurologic disorders/Migraines			
10. Asthma/Reactive Airway disease			
11. Unexplained sudden death			
12. Alcohol/drug dependency			

Current Health *Have you noticed any of the following symptoms in your child or does your child complain of:*	**Yes**	**No**	**Comments**
1. Constitutional: Unexplained weight loss/gain, fever, chills, sweats, fatigue			
2. Eyes: Glasses/contacts, blurred/double vision			
3. ENT: Ringing in ears/hearing problems			
4. CV: chest pain/heart palpitations			
5. Respiratory: shortness of breath/cough/wheezing			
6. GI: nausea/vomiting/heartburn			
7. GU: bowel/urinary problems			
8. Mskl: Joint/bone pain			
9. Neurologic: numbness/tingling/ dizziness/balance problems			
10. Psychiatric: Depression/anxiety/ nervousness			
11. Hematologic: Easy bleeding/ bruising			
12. Skin: Skin problems			
13. Other _____			

Social History

School _____

Grade _____

Performance in school (circle one):

Above Average Average Below Average

What sports/activities does the patient participate in? ❑None (or specifiy below) _____

_____

Do you exercise regularly? ❑ Yes ❑ No (If yes, how many hours per week): _____

Which best describes the patient's living arrangements? (check all that apply)

❑ Lives with both biological parents

❑ Lives with one parent/guardian (circle one) (mother, father, grandparent, other)

- Specify who is the legal guardian (mother, father, other) _____

❑ Lives with adoptive parents

❑ Other (*please explain*) _____

Please indicate parent(s)/guardian(s) occupation: _____

Does the patient smoke? **YES NO** (circle one)

Do any other members in the household smoke? **YES NO** (circle one)

Do you or your child have a need to discuss any emotional or physical harm that you or your child may be experiencing?

_____

Do you ever feel unsafe at home or has anyone hit your child or tried to injure your child?

_____

Patient Signature or Parent/Legal Guardian _____ Date: _____ Time: _____

Reviewed by: _____ Date: _____ Time: _____