Highlands Integrative Pediatrics

Osteopathic Consultation Form

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

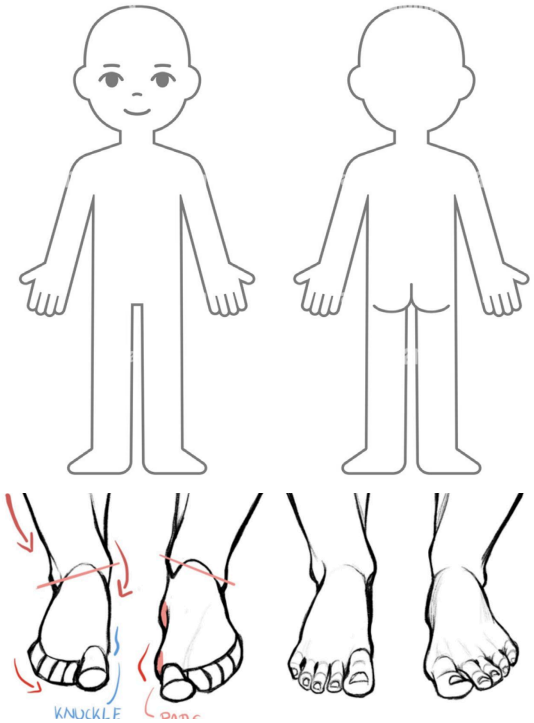
CURRENT STATUS

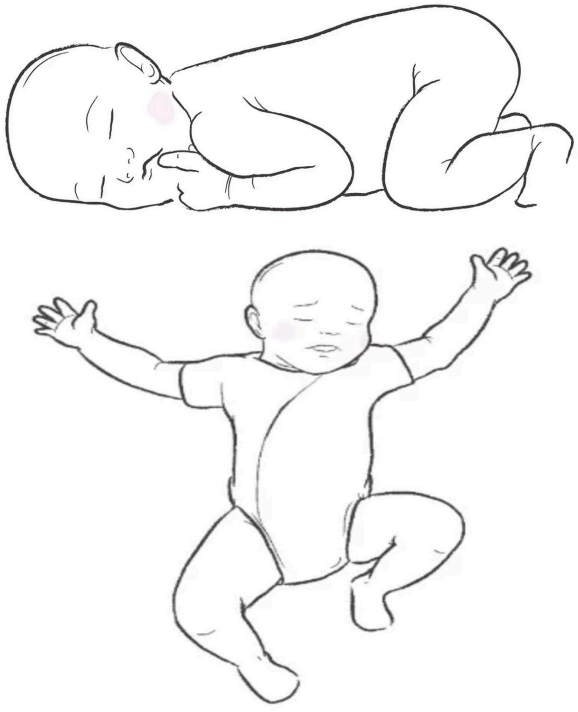
Primary Problems

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?_____

Imaging: Please list all prior imaging you have (Xrays, CTs, MRIs):_____

_____

_____

Lab work: Please list recent bloodwork you have had:_____

Health providers

Name and Specialty	What do you see them for?

Other medical conditions/diagnoses

Condition/Diagnosis	Date diagnosed	Treatment and Self-care approach

Please list all medications, supplements, herbs, remedies and vitamins that taken:

Name of drug:	Dosing:
	_____mg _____times per day/week
	_____mg _____times per day/week
	_____mg _____times per day/week

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	_____mg _____times per day/week

Please list all allergies and intolerances:

Drug, food or other substance:	Reaction:

PAST MEDICAL HISTORY

BIRTH HISTORY:

1. Conceived by: Expected_____ Unexpected_____ Naturally _____ IVF _____
2. Gestational age at birth (40 weeks is full term)_____
3. Prenatal problems: _____
4. How did mother go into labor?
   Naturally went into labor? _____ Induction for: _____ C-section because:_____
5. Medications in pregnancy, labor or delivery? _____
6. Stressors in pregnancy? _____
7. Time in labor: _____
8. Time pushing:_____
9. Delivery type: C-section/Vaginal Delivery;
10. Presentation of baby: Head First/Breech/Transverse
11. Procedures used: Vacuum/Forceps/Other_____
12. Birth weight:____lbs ____oz Length _____inches
13. First cry: Strong/Weak/No Recall APGAR score: _____
14. Immediate to breast? YES/NO Breast or Bottle Fed Strong Suck? YES/NO
15. Complications Mother: _____
16. Complications baby: _____
17. Spit up? YES/NO Projectile vomit? YES/NO Colic? YES/NO
18. If/when breast feeding does mother follow any special diet? _____
20. Formula Current type:_____
21. Prior types of formula used and why changed?_____
22. Feeding schedule:_____

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: _____

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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.	_____	_____	_____	_____

SOCIAL HISTORY:

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

DEVELOPMENTAL HISTORY:

Milestones met on time? (fine/gross motor skills, language etc.): _____
Academic/Athletic performance:_____
Social skills (w/peers, w/adults):_____

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, naps):_____
Immunizations: Up to Date? YES/NO; Delayed or Regular Schedule:_____ NONE:_____
Vaccine reactions in the past? _____NONE:_____

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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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FAMILY HISTORY:

	Age	Health Status	Death/Cause/Age
Father:	_____	_____	_____
Mother:	_____	_____	_____
Siblings:	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

Are there are any relatives with symptoms similar to the child's reason for this visit today?
If yes, please list:

_____
_____

HEALTH PROBLEMS: (in any blood relative) NONE:____

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

Other Problems (not listed above):_____NONE:____

_____

Is there anything else you wish to share? _____

_____

Signed:_____Date:_____