KEYSTONE CHIROPRACTIC

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PEDIATRIC NEW PATIENT SYMPTOMATIC

Patient Name: _____ **DOB** _____ **Date:** _____

1. What is child's major symptom? _____
2. What does this prevent child from doing or enjoying? _____
3. If this is a recurrence, when was the first time you noticed this problem? _____
   How did it originally occur?_____
   Has it become worse? Stayed the Same ___ Better ___ Worse _____
   If worse, when is it worse? Does anything contribute to this worsening? _____
   _____
4. How frequent is the condition? Constant _____ Daily ____ Intermittent ____ Night Only _____
   How long does it last? All Day _____ Few Hours _____ Minutes _____
5. Are there any other conditions or symptoms that may be related to child's major symptom?
   Yes _____ No _____. If yes, describe: _____
   Are there other unrelated health problems? Yes _____ No _____. If yes, describe _____
   _____
6. Describe the symptoms: Sharp _____ Dull_____ Numbness _____ Tingling _____ Aching _____
   Burning _____ Stabbing _____ Other _____
7. Is there anything you can do to relieve the problem? Yes ___ No ___. If yes, describe _____
   _____. If no, what have you tried to do that has not helped? _____
   _____
8. What makes the problem worse? Standing ____ Sitting _____ Lying _____ Bending _____
   Lifting _____ Twisting _____ Walking _____ Other _____
9. List any major accidents your child may have had other than those that might be mentioned above:
   _____
   _____
11. Please circle child's overall pain level below. On the right, label the areas of discomfort with a letter descriptor, and a number pain rating for each area like the sample.

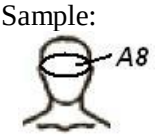
Overall Pain Scale
Please circle the number that best describes your pain

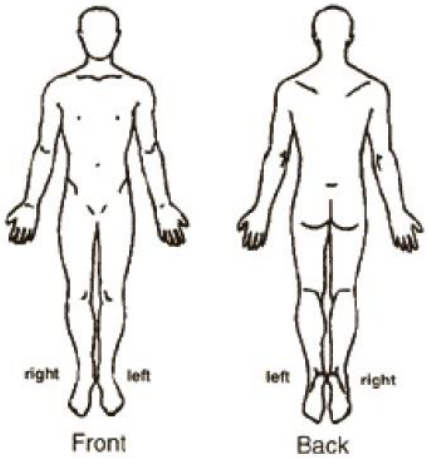
0 1 2 3 4 5 6 7 8 9 10
NONE LITTLE MEDIUM SEVERE

Pain Diagram Key

A = Aching N = Numb
B = Burning T = Tingle
S = Stabbing

Sample:





Remarks: _____
_____

Doctor's Signature _____ Date_____