

**Dr. John Schlechter**  
**Pediatric and Adolescent**  
**Musculoskeletal Questionnaire**

Please answer each question as completely as possible; this information will help with the diagnosis & treatment of your condition. Check boxes to indicate a positive response.

Name \_\_\_\_\_ Age \_\_\_\_\_ yrs \_\_\_\_\_ mo Sex \_\_\_\_\_  
Height \_\_\_\_\_ Weight \_\_\_\_\_ Date of Birth \_\_\_\_\_ School Grade \_\_\_\_\_  
Referred by \_\_\_\_\_

Primary Care Physician/Pediatrician \_\_\_\_\_ Fax # \_\_\_\_\_

Dominant Hand  Right  Left

Body part to be examined:  Right  Left

- |                                      |                                |                                     |
|--------------------------------------|--------------------------------|-------------------------------------|
| <input type="checkbox"/> Shoulder    | <input type="checkbox"/> Elbow | <input type="checkbox"/> Wrist/Hand |
| <input type="checkbox"/> Knee        | <input type="checkbox"/> Ankle | <input type="checkbox"/> Hip        |
| <input type="checkbox"/> Other _____ |                                |                                     |

**How** and **When** did the injury occur or the symptoms begin? Date of Injury = \_\_\_\_\_

Type of Sport = \_\_\_\_\_

Did you notice any of the following at the time of injury?

- A "pop"                       tearing sensation                       immediate swelling

What treatment have you received for this problem?

- |   |                          |           |
|---|--------------------------|-----------|
| <input type="checkbox"/> X-ray            | result:                  |           |
| <input type="checkbox"/> MRI/CT Scan      | result:                  |           |
| <input type="checkbox"/> Bone Scan        | result:                  |           |
| <input type="checkbox"/> EMG              | result:                  |           |
| <input type="checkbox"/> Medication       | result:                  |           |
| <input type="checkbox"/> Cortisone        | result:                  |           |
| <input type="checkbox"/> Physical Therapy | result:                  | location: |
| <input type="checkbox"/> Surgery          | what procedure and when: |           |
|   | result:                  |           |

What physician is currently treating you for this condition? \_\_\_\_\_

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Name \_\_\_\_\_

Which of the following describes your pain?

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Sharp             | <input type="checkbox"/> Aching           | <input type="checkbox"/> Burning               |
| <input type="checkbox"/> Constant          | <input type="checkbox"/> Intermittent     | <input type="checkbox"/> Awakens me from sleep |
| <input type="checkbox"/> During activities | <input type="checkbox"/> After activities |  |

Where is your pain located?

- Front     Back     Inner side     Outer side     Top

What aggravates your symptoms?

Which of the following symptoms do you currently have?

- |  |                          |
|--|--------------------------|
| <input type="checkbox"/> Catching or popping       | caused by:               |
| <input type="checkbox"/> Grinding                  | caused by:               |
| <input type="checkbox"/> Swelling                  | caused by:               |
| <input type="checkbox"/> Shooting / radiating pain | from where to where:     |
| <input type="checkbox"/> Numbness / tingling       | where:                   |
| <input type="checkbox"/> Loss of motion            | describe:                |
| <input type="checkbox"/> Weakness                  | with the following uses: |

Does it feel at times like the involved joint dislocated or "slips out"?

Does anything improve your symptoms?

Have you had prior injuries or complaints related to this area of your body?  
(If yes please describe the injury and its prior treatment.)

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Name \_\_\_\_\_

**HEALTH HISTORY**

*This information will remain confidential and will not be released without patient authorization.  
Please be as complete as possible and print clearly.*

Drug Allergies / Sensitivities: (Please describe the adverse reaction) \_\_\_\_\_

Medical Illnesses:	<u>Yes</u>	<u>No</u>	<u>Explain all YES answers</u>
Heart Disease / Condition	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bleeding Disorder / Tendency	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sickle Cell Anemia	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hepatitis / Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
HIV	<input type="checkbox"/>	<input type="checkbox"/>	_____

Previous Surgeries: \_\_\_\_\_

Current Medications (include herbs, supplements and diet pills) \_\_\_\_\_

Family History (Any medical problems in your family) \_\_\_\_\_

**Social History:**

- Do you currently smoke cigarettes?  Yes  No \_\_\_\_\_ packs daily
- Do you drink alcohol?  Yes  No
- Do you use any other drugs?  Yes  No

Sports and leisure activities: \_\_\_\_\_

Signature \_\_\_\_\_ Physician \_\_\_\_\_

## PATIENT CONSENT AND WAIVER FORM

I, \_\_\_\_\_, understand that I am, or will be, responsible for all of the charges associated with my appointment today, as well as any subsequent appointments relating to the testing, x-rays, diagnosis, and all treatment, including, but not limited to the following items:

- 1. ALL DURABLE MEDICAL EQUIPMENT, IF NOT COVERED BY INSURANCE PLAN.**
  - 2. NO REFERRAL AT TIME OF VISIT:** If you wish to be seen today, but did not bring a referral with you, nor do you have a valid referral already here in the office, you will be responsible for all charges.
  - 3. NO INSURANCE:** You will be responsible for all charges associated with all visits.
  - 4. MISSED APPOINTMENTS:** Appointments are confirmed prior to your appointment date. If an appointment is cancelled up to 24 hours prior, you will not be charged. If you fail to show up for your confirmed appointment, you will be charged \$25.00.
  - 5. CHANGES IN INSURANCE:** All co-pays and fees are due in full at the time of service.
  - 6. DELINQUENT ACCOUNTS:** In the event that your account becomes delinquent, you will be liable for all reasonable collection/attorney fees plus filing costs and processing fees.
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Patient or Responsible Party:

Signature \_\_\_\_\_ Date \_\_\_\_\_