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

☐ Shoulder ☐ Elbow ☐ Wrist/Hand

☐ Knee ☐ Ankle ☐ Hip

☐ 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?

☐ X-ray result:

☐ MRI/CT Scan result:

☐ Bone Scan result:

☐ EMG result:

☐ Medication result:

☐ Cortisone result:

☐ Physical Therapy result: location:

☐ 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?

- ☐ Sharp
- ☐ Aching
- ☐ Burning
- ☐ Constant
- ☐ Intermittent
- ☐ Awakens me from sleep
- ☐ During activities
- ☐ 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?

☐ Catching or popping	caused by:
☐ Grinding	caused by:
☐ Swelling	caused by:
☐ Shooting / radiating pain	from where to where:
☐ Numbness / tingling	where:
☐ Loss of motion	describe:
☐ 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 / Sensitivitie: (Please describe the adverse reaction) ______________________________

____

____

Medical Illnesses:	Yes	No	Explain all YES answers
Heart Disease / Condition	☐	☐	________
High Blood Pressure	☐	☐	________
Asthma	☐	☐	________
Diabetes	☐	☐	________
Seizures	☐	☐	________
Bleeding Disorder / Tendency	☐	☐	________
Sickle Cell Anemia	☐	☐	________
Cancer	☐	☐	________
Kidney Disease	☐	☐	________
Mental Illness	☐	☐	________
Hepatitis / Liver Disease	☐	☐	________
HIV	☐	☐	________

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 ______________________________

Thank You For Filling Out This Form