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 / Sensitivities (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