PEDIATRIC Osteopathic Manual Medicine Intake Form Supplement

Child Name: _____Date of Birth: _____

Guardian Name: _____

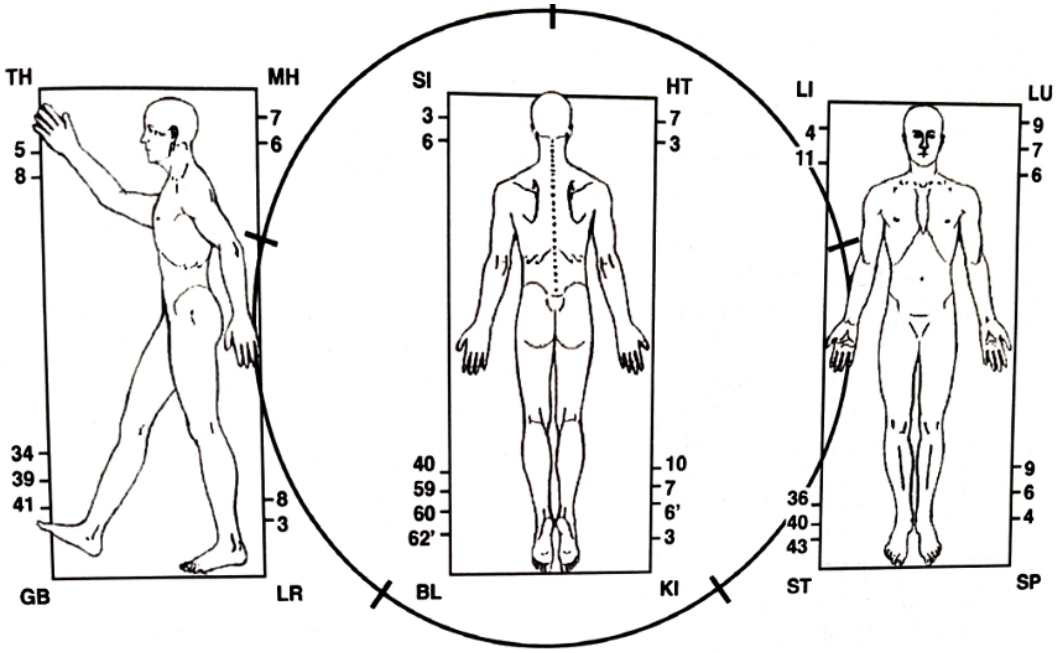
Main Concern(s):

1._____

2._____

3._____

Please mark areas of pain/symptom with X; O for tingling/numbness as accurately as possible.



Pain/Symptom Assessment- Side	Pain/Symptom Assessment- Back	Pain/Symptom Assessment- Front
Location: L/R/B	Location:	Location:
Onset:	Onset:	Onset:
Better with:	Better with:	Better with:
Worse with:	Worse with:	Worse with:
Associated symptoms:	Associated symptoms:	Associated symptoms:
Quality: ☐Constant ☐Intermittent ☐Dull ☐Sharp ☐Pressure ☐Burning	Quality: ☐Constant ☐Intermittent ☐Dull ☐ Sharp ☐Pressure ☐Burning	Quality: ☐Constant ☐Intermittent ☐Dull ☐Sharp ☐Pressure ☐Burning
Severity: 1☐2☐3☐4☐5☐6☐7☐8☐9☐10☐	Severity: 1☐2☐3☐4☐5☐6☐7☐8☐9☐10☐	Severity: 1☐2☐3☐4☐5☐6☐7☐8☐9☐10☐

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SUNRISE FAMILY MEDICINE, PLLC
DR. TUAN M. VO, DO, MPH

How long has child had the pain/symptoms? _____

How often does the pain/symptom occur?

Continuous __ 1-2x day __ 3+x/day __ Few x/wk __ few x/month __

What activities was the child participating in leading up to the symptoms?

_____

Do the symptoms move from one area to another? _____

Are the symptoms more pronounced with any activity, position, time of day, exposure?

_____

_____

What imaging/testing has been done to evaluate your pain/symptoms? When?

1._____
2._____
3._____

What treatments have been tried before (OMT/OMM/Chiropractic/Massage/Injections/Other)? How did they work?

_____

_____

_____

_____

_____

How do your symptoms limit the child's daily activities/play/learning/behavior/sleep/eating?

_____

_____

_____

_____

_____

_____

How do these limitations affect the child's quality of life, relationships with other family, friends, etc.?

_____

_____

_____

_____

_____

Thank you for completing this form.