Winchester Hospital
A member of Lahey Health

Orthopaedics Plus

Patient Medical Record Number: _____		
Patient Name: _____		
Patient Email: _____		
Child is a new patient:	**yes**	**no**
Child is a returning patient:	**yes**	**no**
Child had physical therapy this year:	**yes**	**no**

Pediatrician: _____ **Referring Physician:** _____

1. Pediatric Medical History

Child's diagnosis or reason for referral: _____

Is this visit related to an accident or injury? yes no

when/where_____

Previous treatment for similar symptoms yes no

when/where_____

Has there been a hospitalization, major surgical procedure, major illness yes no

when/where_____

Height in inches:	Weight in pounds:
Language spoken:	Siblings and ages:
Allergies:	Immunizations needed:
☐ Glasses for Vision	☐ Pain, Location_____

Past Medical History: (Please circle or place an x for those that apply)

☐ Childhood Diseases	☐ Rheumatologic Conditions (Arthritis)
☐ Chronic Colds	☐ Digestive Disorders (Reflux, Bowel, Bladder)
☐ Asthma/Bronchitis	☐ Autism Spectrum Disorder
☐ Other Respiratory Illnesses	☐ Psychiatric/Emotional Disorder
☐ Neurological Disorders (Seizures, Meningitis, Brain injury, Cerebral Palsy)	☐ Other Developmental Condition
☐ Orthopedic Conditions	

Current Medications: (If you have a list with your child's medications, please let us know)

☐ Not currently taking any medications
☐ Prescription
☐ Non Prescription/Over the Counter/Vitamin/Mineral/Dietary Supplements/Herbal/Other

Equipment Used: (Please circle or place an x for those that apply)

☐ Splints, Orthotics	☐ Communication Devices
☐ Mobility or Seating Devices	☐ Other

Educational History: (Please circle or place an x for those that apply)

☐ Day Care Center	☐ Family Day Care	☐ In home care provider
☐ Early Intervention	☐ Head Start	☐ Preschool
☐ Elementary School	☐ Middle School	☐ High School
☐ Regular Education	☐ Special Education	☐ IEP

Comments: _____

Developmental History: (Please provide as much information as you can)

Motor Skill Development	Achieved	Not Achieved	Comments or explanation
Reached for objects			
Grasped objects			
Rolled over			
Sat independently			
Crawled on belly			
Crawled on hands and knees			
Stood independently			
Walked independently			
Ran			
Rode trike			
Ride bike			
Fed self			
Used utensils			
Drank from sippy cup			
Drank from straw			
Drank from open cup			
Dressed/undressed self			

Do you have any concerns about your child's strength, balance or coordination? _____

_____

Does your child participate in extra-curricular activities? _____

What does your child enjoy playing with? _____

Do you feel your child is able to keep up with other children of the same age?	yes	no
Does your child have difficulty falling asleep?	yes	no
Does your child stay asleep?	yes	no
Does your child tolerate tooth brushing, hair brushing, hair cuts, dentist visits, bathing?	yes	no
Is your child distracted by or over sensitive to sound?	yes	no
Does your child play on a variety of playground equipment?	yes	no
Does your child eat a variety of foods?	yes	no
Does your child seem overly active?	yes	no
Does your child tire easily?	yes	no

Does your child avoid/crave cuddling? (please circle)

Does your child avoid/have difficulty with eye contact? (please circle)

2. Early Life History

Prenatal/Birth History: (please explain)

☐ Breech	☐ Vacuum/Forceps
☐ C-Section	☐ Intrauterine Constraint
☐ Special Care	☐ NICU

Birth Weight:
Gestational Age:
Multiple Birth: (please explain)
Age Torticollis Diagnosed and by whom:
Cervical X-rays and Ultrasound Results:
Hip X-rays and Ultrasound Results:
Feeding Problems/Reflux: (please explain)
☐ Breast ☐ Bottle, Formula Type
Other Medical Problems/Consultation: (please explain)
Other comments:

Sleep History:

Does/did your child sleep in a crib? yes no

How many hours at a time does your child sleep? _____

What positions does your child sleep in? _____

Play Equipment: (Please circle or place an x for those that apply)

☐ Car Seat	☐ Bouncy Seat
☐ Swing	☐ Other
☐ Rock and Play Sleeper	

Tummy Time:

Does/did your child tolerate tummy time? yes no

Other:

What is your child's preferred position? _____

Has your child been seen by any specialists? yes no

Patient Goals:

Questions:

Parent/Guardian Signature: _____Date: _____Time: _____