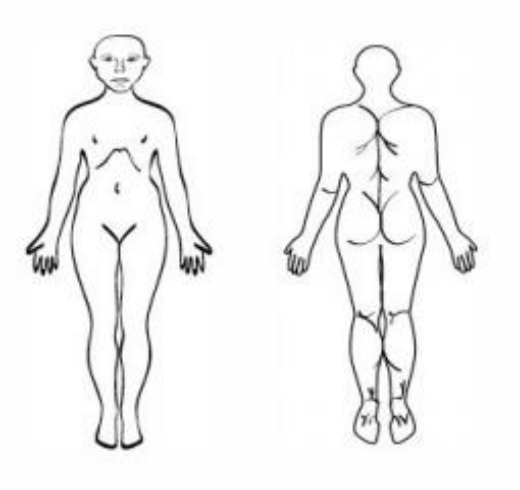
SWEDISH PEDIATRICS
Extraordinary care. Extraordinary caring.℠

Supplemental Orthopedic Intake Questionnaire

Reason for visit: (briefly describe, injury/pain/reason for visit)
Date of Injury/Onset of Symptoms:
Has this ever happened before **Yes** **No** If yes, please briefly explain:

Please note on the diagram where your child is experiencing pain/symptoms:



Rate pain on scale of 0-10
(10 being worst pain imaginable):
_____ At present
_____ At best
_____ At worst

What makes your pain worse?
□ Sitting □ Walking □ Running □ Stairs
□ Standing □ Lying down □Bending over

What makes your pain better?
□ Ice □ Rest □ Sitting □ Lying down
□ Heat □ Pain medication

School/Academic Information:
School currently attending:
Grade:
Leisure/Recreational/Sport Activities: