

Spine and Sport Biomechanical Rehabilitation Center- Child Subjective Pain Form

Childs Name: _____ Today's Date: _____

Mothers Name: _____ Fathers Name: _____

Date of Birth & Age: _____ Date of Pain Onset: _____

From birth to current please describe major illnesses, medical issues, or hospitalizations that your child has had and when:

0 = No Symptoms/Pain 5 = Moderate 10 = Excruciating

What is your child's current level? (Circle) 0 1 2 3 4 5 6 7 8 9 10

What has your child's symptom/ pain / discomfort range been (best and worst) in the past 30 days? 0 1 2 3 4 5 6 7 8 9 10

When did you first become concerned about your child's development/current issue? _____

Has child received occupational, physical, or speech therapy currently or in the past? (please list providers)

At what age was each major milestone reached: Sitting up by self: _____ Crawling: _____ Walking: _____ Talking: _____

Did mother have any illnesses or complications during pregnancy or delivery? Please describe:

____ Natural Birth ____ C-Section Was child premature? Yes or No Birth Weight: _____

Did your child have any feeding problems as an infant? Please describe: _____

Did they have any colic or reflux issues? _____

Does your child have any allergies? Please list: _____

Problems sleeping? Yes or No Problems eating? Yes or No Problems hearing/ ear infections? Yes or No

Explain: _____

What is child's most tolerable position? (Circle) Lying Sitting Walking Standing All positions are the same

What is child's least tolerable position? (Circle) Lying Sitting Walking Standing All positions are the same

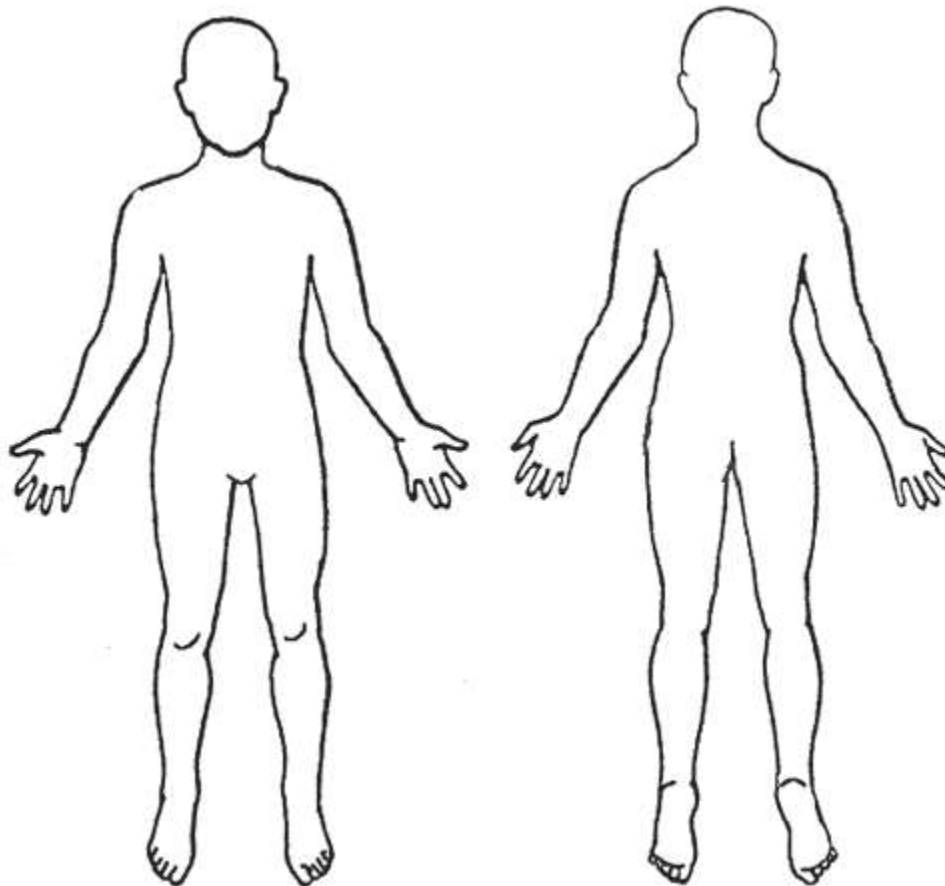
Has child had any problems in bowel or bladder functions? Yes or No If yes, state changes: _____

List all current medications and condidtion for medication below: _____

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Body Diagram

Please indicate where child's symptom/ pain / discomfort is located and what type of pain they feel at the *present* time. Fill in the area on the body diagram with the appropriate symbols below to describe pain.



Key:
Stabbing: ///
Burning: XXX
Pins and Needles: 000
Numbness: ===
Other: (●●●)_____

Visual Analogue Scale

Make a slash (/) along the line from the extremes, which you think represents child's current symptom / pain.

No Symptoms/Pain at All

Pain as Bad As It Could Be



Is there any additional information/concerns you feel we should know?
