SCOLIOSIS ASSOCIATES

PATIENT HISTORY QUESTIONAIRE

(Please fill in all necessary information)

Patient Name: ____________________________ Today's Date:__________________

1. Complaint/ reason for coming to doctor's office:
☐ Scoliosis ☐ Kyphosis ☐ Round back ☐ Back pain ☐ Other__________

2. Check any SYMPTOMS you are having: ☐Pain ☐Swelling ☐Weakness ☐Numbness
Location: ☐Neck ☐Upper Back ☐Low Back ☐Arm (right/left) ☐Leg (right/left)
Pain scale: 0_______5_______10 Back: Leg pain ratio (Dr. will fill out with you)
No Pain Unbearable __________:__________
When did it begin? ________________ Is the condition: ☐Intermittent ☐Constant
Was it caused by an accident? ☐yes ☐no Explain (Date) _____________________________
What makes the condition worse? ____
What makes condition better? ____
Bowel and Bladder Function: Normal ☐ Abnormal Explain_________________
Have you seen another healthcare provider for this problem? ☐Yes ☐No Doctor: __________

3. PREVIOUS SPINE TREATMENT: ☐Brace ☐Trigger Point Injection ☐Epidural injections
☐Narcotics Medication (Vicodin, Tylenol #3) ☐Anti-inflammatory medication ☐Physical Therapy ☐Shoe Lift ☐Chiropractic ☐Acupuncture ☐ Other________

4. BODY APPEARANCE: ☐Losing height ☐Waistline changes ☐Shoulders uneven ☐Hump

5. FUNCTION: ☐No limitations in activities ☐Limited ability to play sports ☐Work restricted
☐Unable to work ☐ Walking: no limit ☐Blocks able to walk______ ☐Cane ☐Walker

6. PRENATAL HISTORY: ☐Premature ☐Full Term ☐C-Section ☐Induced ☐Adopted

7. DEVELOPMENT: ☐Normal ☐Delayed ________________________
Date of 1st menstrual period________________

8. PAST MEDICAL HISTORY: ☐None ☐Heart disease ☐Hypertension ☐Lung disease ☐Asthma
☐ Gastric ulcer ☐ Kidney disease ☐ Blood clots ☐Osteoporosis ☐ Bleeding disorders
☐Hepatitis/HIV ☐Stroke ☐Hearing problems ☐Psychological disorders
☐Eye problems ☐other_____________________

PAST SURGERIES:_____________________________

9. MEDICATIONS taken daily____

10. ALLERGIES: ____

11. FAMILY HISTORY: Scoliosis__________ Kyphosis_________ Family member with __________

12. SOCIAL HISTORY: Occupation: ___________________________________
Do you smoke? ☐Yes ☐No Packs/day__________ Do you drink alcohol? ☐Yes ☐No
History of drug abuse? ____