

**SCOLIOSIS INFORMATION**

**Date Filled Out** \_\_\_\_\_

\_\_\_\_\_  
 Last Name First Name MI Age Birth date  
 Occupation: \_\_\_\_\_ Gender M F

**Who First Noticed the Scoliosis?**

- Me
- Parents or Siblings
- School Screening
- My Doctor Name of Doctor \_\_\_\_\_

**Primary Care Doctor's Name**

\_\_\_\_\_

**Other Doctors Names**

\_\_\_\_\_

**How Long Ago Was it First Noticed?** \_\_\_\_\_

**Have You Had Any Tests Done For This?**

- X-rays
- MRI
- Bone Scan
- CAT Scan
- Myelogram

**What Treatments Have You Had For This?**

- Nothing
- Electrical Stimulation
- Physical Therapy
- Brace
- Back Exercises
- Chiropractic
- Massage
- Other: \_\_\_\_\_

**Current Symptoms**

Do you have any of these **Symptoms now?**

- Back Pain
- Shoulder Pain Rt. Lt.
- Leg Pain Rt. Lt.
- Numbness Where: \_\_\_\_\_
- Tingling Where: \_\_\_\_\_
- Arm or Leg Muscle Weakness
- Explain: \_\_\_\_\_
- Trouble Controlling Bowels or Bladder
- Pain with Coughing, Sneezing or Straining
- Pain that wakes you from Sleep

**Does Anyone Else in Your Family**

**Have Scoliosis? Yes No**  
**If Yes Who?** \_\_\_\_\_

**If you have a family member with any of the following diseases please check.**

- Marphan's
- Neurofibromatosis
- Muscular Dystrophy
- Charcot-Marie-Tooth

Do you get any **Regular Exercise?** Yes No If Yes What? \_\_\_\_\_  
 How Many days per Week? \_\_\_\_\_

Do You Have Any of the Following **Symptoms?** (Check all that apply.)

- Feeling Sick Weight Loss Fevers Shaking Chills Nausea
- Morning Stiffness
- Electrical Shock Feelings Visual Disturbance Balance Problems
- Trouble Writing Difficulty with fine manipulations
- Buzzing Sensation in Arms or Legs

**Previous Scoliosis Treatment**

Have You Had **Surgery on Your Back** Before? Yes No  
 If Yes Please List the Type of **Operation**, Approximate Year, and Doctor's Name

- |    | <u>Operation</u> | <u>Year</u> | <u>Doctor</u> |
|----|------------------|-------------|---------------|
| 1) | _____            | _____       | _____         |
| 2) | _____            | _____       | _____         |
| 3) | _____            | _____       | _____         |
| 4) | _____            | _____       | _____         |

**Past Surgical History**

(Don't include operations listed above)

**Social History**

How Far Did You Get In **School**?

- Didn't Graduate High School      HS Grad
- Some College      College Grad
- Professional or Advanced Degree

Are You **Married**?    Yes    No

How Many **Children**?    1    2    3    4    5    6

Are You **Working**?    Disabled    Retired    Working  
                          Parenting    Taking Time off    Unemployed

**Operation**

**Year**

- 1) \_\_\_\_\_
- 2) \_\_\_\_\_
- 3) \_\_\_\_\_
- 4) \_\_\_\_\_
- 5) \_\_\_\_\_
- 6) \_\_\_\_\_
- 7) \_\_\_\_\_

**Previous Medical Problems**

Please Check Any Medical Problems You Have Had or Currently Have

**Cardiac**

- Hypertension
- Coronary Artery Disease
- Myocardial Infarction
- Congestive Heart Disease
- Atrial Fibrillation
- High Cholesterol

**Respiratory**

- COPD
- Asthma

**Endocrine**

- Diabetes
- Hypo- Thyroidism
- Hyper – Thyroidism

**GI**

- Irritable Bowel Syndrome
- Colon Cancer
- Diverticulitis
- GE Reflux
- Hepatitis
- Ulcer Disease

**Urinary and Genital**

- Enlarged Prostate
- Kidney Stone
- Urinary Tract Infection
- Prostate Cancer
- Bladder Cancer
- Renal Cancer
- Ovarian Cancer
- Uterine Cancer

**Musculoskeletal**

- Degenerative Arthritis  
Of: \_\_\_\_\_
- Rheumatoid Arthritis
- Fibromyalgia
- Neck Pain
- Upper Back Pain

**Skin**

- Melanoma
- Other Skin Cancer
- Psoriasis

**Neurologic**

- Multiple Sclerosis
- Parkinson's
- Stroke
- Peripheral Neuropathy

**Psychiatric/ Emotional**

- Alcoholism
- Drug Use / Abuse
- Depression
- Anxiety Disorder
- Bipolar Disorder

**Blood Disorders**

- HIV
- Bleeding Disorder
- Anemia
- Leukemia
- Lymphoma

**Ear/Nose/ Throat**

- Lip/ Tongue or Throat Cancer
- Chronic Sinusitis
- Hearing Problems

Enter **Any Other Medical Problems Not Listed** Above Here: \_\_\_\_\_

Please List Any **Allergies to Medicines**? \_\_\_\_\_

Please List **All Regular Medications**? \_\_\_\_\_

Do You **Smoke**?    Yes    No    If Yes, how many packs per Day: \_\_\_\_\_

**Alcohol:** How Many **Drinks**, Glasses of Wine or Beers **per Day**:    **Never**    <1    1    2    3    4    5

Are there Any **Medical Problems That Run in the Family**?

\_\_\_\_\_

\_\_\_\_\_