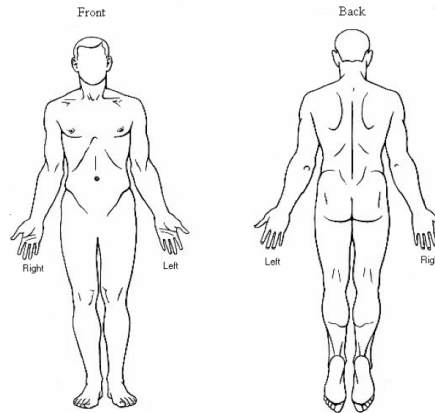


Patient Name: _____ Age: _____ Date: _____

Please complete all questions. All responses will remain confidential.

1. If you have scoliosis/kyphosis, when was it first discovered? (Month/Year) _____
2. If you are having pain, please mark where your pain is on the diagram below:

Front Back

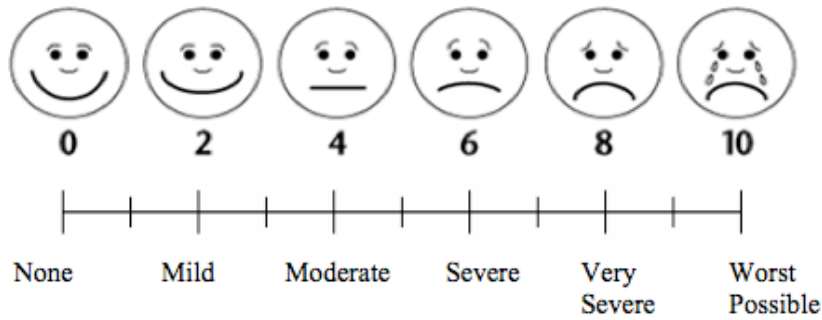


Use the body diagrams to show where you feel the following sensations.

Ache	Numbness	Burning	Stabbing
AAA	000	XXX	///
AAA	000	XXX	///
AAA	000	XXX	///

Pins And Needles
≡ ≡ ≡

3. Please place an X on the hash mark that most accurately describes your pain now:



0 2 4 6 8 10

None Mild Moderate Severe Very Severe Worst Possible

4. What tests have been done for this problem?

None X-rays MRI CT scan Other: _____

5. What treatments have you tried for this problem? _____

6. Please list all Care Givers that have treated you for this condition: _____

7. Does anyone else in your family have scoliosis or kyphosis? Yes No

If yes, what relation and what type of treatment did they receive? _____

8. Females only: Have you started your periods? Yes No

If yes, when did they begin? (Month/Year) _____

9. Is there anything else that you think we should know about? _____

Past Medical History

Have you ever had problems with: (check all that apply)

- Heart Lungs Kidneys Bladder Stomach Eyes, Ears, Nose or Throat

Please list current medical problems: _____

Past Surgical History

Surgical Procedure	Date	Complication

Medications

Medication	Dose	Frequency
Example: Motrin	600 mg	Three times a day

Allergies _____ No known drug allergies

Are you allergic to Latex? Yes No

Social History Which school do you attend? _____ Grade? _____

Who do you live with? Mom Dad Siblings Other: _____

How many siblings? _____ Brothers _____ Sisters Pets? _____

Family History

Do you have a family history of:

Scoliosis / Kyphosis? Yes No Blood clots or other bleeding disorders? Yes No

Heart disease? Yes No Adverse reactions to anesthesia? Yes No

Cancer? Yes No If yes, what type? _____

Other? _____

Review of Systems

Do you have any current (within the last few weeks) problems with:

Constitutional symptoms

- Good general health Yes No
Fever Yes No
Unexplained weight change Yes No

Eyes

- Wear glasses or contacts Yes No
Change in vision Yes No

Ears, nose, mouth, throat

- Change in hearing ability Yes No
Nose bleeds Yes No
Swallowing difficulty Yes No

Cardiovascular

- Chest pains Yes No
Heart problems Yes No
Swelling of feet or ankles Yes No
Sudden heartbeat changes Yes No

Respiratory

- Shortness of breath Yes No
Frequent coughing Yes No
Asthma or wheezing Yes No

Gastrointestinal

- Nausea or vomiting Yes No
Change in bowel movements Yes No
Abdominal pain Yes No

Genitourinary

- Frequent urination Yes No
Burning or painful urination Yes No
Blood in urine Yes No
Urinary incontinence Yes No

Females only:

- Painful periods Yes No
Irregular periods Yes No

Date of last menstrual period _____

Musculoskeletal

- Joint pain Yes No
Joint stiffness or swelling Yes No
Weakness Yes No
Difficulty walking Yes No
Back pain Yes No
Muscle pain or cramps Yes No

Integumentary

- Rash or itching Yes No
Change in skin, hair or nails Yes No

Females only:

- Breast pain or lumps Yes No

Neurological

- Frequent headaches Yes No
Dizziness Yes No
Seizures Yes No
Head injury Yes No

Psychiatric

- Depression Yes No
Anxiety Yes No
Sleep problems Yes No

Endocrine

- Heat or cold intolerance Yes No
Change in hat or glove size Yes No
Excessive thirst or urination Yes No

Hematologic/lymphatic

- Easily bruise or bleed Yes No
Slow to heal after cuts Yes No
Swollen glands Yes No

Allergic/immunologic

- Hay fever Yes No
Recurrent infections Yes No

I attest that the above answers are true and have been completed to the best of my knowledge.

Patient or Parent Signature: _____

Date/Time: _____

I have reviewed the history and review of systems.

Physician Signature: _____

Date/Time: _____