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:
	□ Kyphosis □ Round back □ Back pain □ Other
2. Check any SYMPTOMS you are having: Dain Swelling Weakness Numbness	
Location: Deck	Upper Back Low Back Arm (right/left) Leg (right/left)
Pain scale: 0	_510 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 a	accident? 🛛 ves 🖓 no Explain (Date)
What makes the cond	lition worse?
what makes conditio	
Bowel and Bladder F	unction: Normal 🗆 Abnormal Explain
Have you seen anothe	er healthcare provider for this problem? □Yes □No Doctor:
3. PREVIOUS SPINE TREATMENT: DBrace Trigger Point Injection Epidural injections Narcotics Medication (Vicodin, Tylenol #3) Anti-inflammatory medication Physical Therapy Shoe Lift Chiropractic Acupuncture Other	
петару Цэп	be Ent Demropractic DAcupuncture Dotner
4. BODY APPEARANC	E: DLosing height DWaistline changes DShoulders uneven DHump
5. FUNCTION: DNo limitations in activities DLimited ability to play sports DWork restricted DUnable to work DWalking: no limit DBlocks able to walk DCane DWalker	
6. PRENATAL HISTORY: Premature Full Term C-Section Induced Adopted	
7. DEVELOPMENT: Normal Delayed	
8. PAST MEDICAL HISTORY: Done Deart 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 SURGER	RIES:
9. MEDICATIONS take	n 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?	