Scoliosis Initial History Form

When were you diagnosed? ______________________________

How were you diagnosed? ______________________________

When was your first period (girls)? ______________________________

Have you had your growth spurt? When? ______________________________

Any family history of scoliosis? Who? ______________________________

What treatments have you had? ______________________________

Have you noticed a change in the way your clothes fit? ______________________________

My symptoms are in my right/left/both (circle one): ___ back ___ buttock ___ hip

___ thigh (front/back/middle/outside) ___ leg (shin/outer calf/back of calf)

___ inside/outside/top/bottom foot (circle all that apply)

My pain level is (circle the appropriate number):

On average

0----1----2----3----4----5----6----7----8----9----10

At its worst

0----1----2----3----4----5----6----7----8----9----10

My symptoms feel like: ___ numbness ___ tingling ___ stabbing ___ burning ___ achy

___ pins and needles ___ other: ______________________________

My symptoms are worse when I: ___ bend ___ twist ___ lift ___ sit ___ drive ___ walk ___ stand

___ housework ___ lie down ___ other: ______________________________

My symptoms are better when I: ___ bend ___ twist ___ lift ___ sit ___ drive ___ walk ___ stand

___ housework ___ lie down ___ other: ______________________________

I have tried: ___ PT (Dates ________) ___ Chiropractor ___ Heat ___ Ice ___ Massage ___ Traction

___ Pain meds or Muscle relaxants (please list ______________________________)

___ Epidurals (Dates ____________) ___ Other injections (Types ____________________)

Previous spinal surgeries (Date/Procedure/Surgeon)

____

____

Other symptoms: ___ fever ___ chills ___ nausea ___ vomiting ___ night sweats ___ night pain

___ weigh loss/gain ___ bowel problems ___ loss of urinary control

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