Confidential Patient Medical History

Date:_____ _____ Date of last physical:_____

Name:_____ Date of Birth:_____

Present Complaints:
Are you here for the evaluation/ treatment of scoliosis? Yes_____ No_____
Do you have any complaints associated with or in addition to scoliosis: Yes_____ No_____
Have you been diagnosed with scoliosis? Yes_____ No_____

Please describe any CURRENT complaints and rate their pain from 1-10.
(1 being least serious/ painful and 10 being most serious/ painful)

1._____1-2-3-4-5-6-7-8-9-10

2._____1-2-3-4-5-6-7-8-9-10

3._____1-2-3-4-5-6-7-8-9-10

4._____1-2-3-4-5-6-7-8-9-10

When and how did your complaint(s) occur? _____
_____

Symptoms appeared to develop from: (check each one that applies to your symptoms)

SCOLIOSIS _____ JOB RELATED INJURY_____ AUTO ACCIDENT_____ ACCIDENT _____ BIRTH_____

ILLNESS_____ UNKNOWN CAUSE_____ GRADUAL ONSET_____ date occurred:_____

Symptoms have persisted for: Hours____ Day(s)____Week(s)____Month(s)_____Yr(s)_____
Symptoms are typically worse in the A.M._____ Afternoon_____ P.M. _____
Symptoms and/ or complaints: Come and Go_____ Are Constant_____
Have you ever had this before: No_____ Yes (when?)_____
If you were to guess, what do you think caused the problem/ pain?_____

Give name and location of doctors previously seen for this/ these condition(s):_____
_____
_____

Please check the following activities that AGGRAVATE your condition:
BENDING____ REACHING____ COUGHING____ SITTING____ TURNING HEAD____ LIFTING_____ SNEEZ-ING____ WALKING____ LYING DOWN____ STANDING____ STRAINING AT STOOL_____

Please check the following activities that relieve your condition:
BENDING____ REACHING____ COUGHING____ SITTING____ TURNING HEAD____ LIFTING_____ SNEEZ-ING____ WALKING____ LYING DOWN____ STANDING____

Please check any ADDITIONAL SYMPTOMS you may be experiencing:

Blurred Vision_____
Buzzing in Ears_____
Cold Feet_____
Cold Hands____
Cold Sweats_____
Confusion_____
Constipation_____
Depression_____
Diarrhea_____
Dizziness_____
Insomnia_____
Light bothers eyes_____
Loss of Balance____
Loss of Smell_____
Loss of Taste_____
Low Resistance to Colds_____
Muscle Jerking_____
Numbness in Fingers/ Arms_____
Numbness in toes/legs_____
Pins and Needles in Arms_____

Face Flushed_____
Fainting_____
Fever_____
Head seems to heavy_____
Headaches_____

Ringing in Ears_____
Shortness of breath_____
Stiff Neck_____
Stomach Upset_____
Coordination Difficulties_____

CURRENT MEDICAL HISTORY

Have you ever been treated for scoliosis? No_____ Yes (when?)_____Name and location of doctors previously seen for scoliosis treatment_____

Have you worn or do you wear a scoliosis brace? No_____ Yes (What type?)_____

Have you been treated for any other health condition in the last year? No____ Yes (describe) _____

_____

Are you allergic to any medications? No_____ Yes (what kind?)_____

Are you taking any medications? No_____ Yes (what kind?) _____

Are you taking nutritional/ vitamin supplements? No____ Yes (what kind?)_____

Are you pregnant? No_____ Yes (date of last menstrual period) _____

Have you ever had a metal implant? No_____ Yes (describe procedure)_____

_____

FAMILY MEDICAL HISTORY

Are you aware of anyone in your immediate family that has/ had scoliosis? (check any that are applicable)
Mother_____ Father_____ Sister_____ Brother_____

Are you aware of anyone in your distant family that has/ had scoliosis? No_____ Yes_____
Who? _____

Please indicate which PAST conditions have been experienced prior to present complaint by checking appropriate person. (S= Self M= Mother F=Father)

Musculoskeletal System

S	M	F	
____	____	____	Head Pain/ Problems
____	____	____	Neck Pain/ Problems
____	____	____	Shoulder Pain/Problems
____	____	____	Arm Pain/ Problems
____	____	____	Hand Pain Problems
____	____	____	Mid back Pain Problems
____	____	____	Chest Pain/ Problems
____	____	____	Stomach Pain/ Problems
____	____	____	Low back Pain/ Problems
____	____	____	Hip Pain/ Problems
____	____	____	Leg Pain/ Problems
____	____	____	Foot Pain/ Problems
____	____	____	Jaw Pain/ Problems

Genito-Urinary System

S	M	F	
____	____	____	Bladder Trouble
____	____	____	Painful/ Excessive Urination
____	____	____	Discolored Urine
____	____	____	Bed wetting

Ear, Eyes, Nose, & Throat

____	____	____	Sinus Problems
____	____	____	Vision Problems
____	____	____	Dental Problems
____	____	____	Sore Throat
____	____	____	Ear Aches
____	____	____	Ringing in Ears
____	____	____	Stuffed Nose

Gastrointestinal System

____ ____ ____Poor/ Excessive Appetite
____ ____ ____Excessive Thirst
____ ____ ____Frequent Nausea
____ ____ ____Vomiting
____ ____ ____Diarrhea
____ ____ ____Constipation
____ ____ ____Hemorrhoids
____ ____ ____Liver Problems
____ ____ ____Gall Bladder Problems
____ ____ ____Weight Trouble
____ ____ ____Abdominal Cramps
____ ____ ____Gas/ Bloating after meals
____ ____ ____Heartburn
____ ____ ____Black/ Bloody Stools
____ ____ ____Colitis

Nervous System

____ ____ ____Excessive Thirst
____ ____ ____Frequent Nausea
____ ____ ____Vomiting
____ ____ ____Diarrhea
____ ____ ____Constipation
____ ____ ____Hemorrhoids
____ ____ ____Liver Problems
____ ____ ____Gall Bladder Problems
____ ____ ____Weight Trouble

Nervous System

____ ____ ____Fatigue
____ ____ ____Allergies
____ ____ ____Loss of Sleep
____ ____ ____Fever
____ ____ ____Tension Headaches
____ ____ ____Migraine Headaches
____ ____ ____Sinus Headaches

Male/ Female

____ ____ ____Menstrual Irregularity
____ ____ ____Menstrual Cramping
____ ____ ____Vaginal Pain/ Infections
____ ____ ____Breast Pain/ Lumps
____ ____ ____Prostate/ Sexual Dysfunction

Cardiovascular/ Respiratory

____ ____ ____Chest Pain
____ ____ ____Short Breath
____ ____ ____Blood Pressure Problems
____ ____ ____Irregular Heartbeat
____ ____ ____Heart Problems
____ ____ ____Lung Problems/ Congestion
____ ____ ____Varicose Veins
____ ____ ____Ankle Swelling
____ ____ ____Stroke

Diseases

____ ____ ____Pneumonia
____ ____ ____Rheumatic Fever
____ ____ ____Polio
____ ____ ____Tuberculosis
____ ____ ____Whooping Cough
____ ____ ____Mumps
____ ____ ____Small Pox
____ ____ ____Measles
____ ____ ____Chicken Pox
____ ____ ____Diabetes
____ ____ ____Cancer
____ ____ ____Influenza
____ ____ ____Pleurisy
____ ____ ____Arthritis
____ ____ ____Epilepsy
____ ____ ____Mental Disorder
____ ____ ____Anemia
____ ____ ____Hepatitis
____ ____ ____Heart Disease
____ ____ ____Thyroid
____ ____ ____Lumbago
____ ____ ____Eczema

SURGICAL HISTORY

Have you ever had surgery to correct scoliosis? No___ Yes (describe procedure) _____

_____

_____

Describe any other surgical procedures you have had.

1._____Date:_____

2._____Date:_____

3._____Date:_____

ACCIDENT HISTORY

___JOB ___AUTO___OTHER 1._____Date:_____

___JOB ___AUTO___OTHER 2._____Date:_____

___JOB ___AUTO___OTHER 3._____Date:_____

SOCIAL HISTORY

HABIT	Heavy	Moderate	Light	None
Alcohol	_____	_____	_____	_____
Coffee	_____	_____	_____	_____
Tobacco	_____	_____	_____	_____
Drugs	_____	_____	_____	_____
Exercise	_____	_____	_____	_____

Patient Signature_____Date_____

Guardian Signature_____Date_____