Name:
DOB:
Chart:
Age:
Date:

THE MOBILE SPINE CENTER
AT THE ORTHOPAEDIC GROUP, P.C.

SCOLIOSIS BACK FORM

NAME: ______________________ **AGE:** ________ **SCHOOL GRADE:** ________

WHO IS YOUR MEDICAL DOCTOR OR PEDIATRICIAN? ______________________

DID ANOTHER DOCTOR OR SCHOOL SCREENING PROGRAM REFER YOU TO US? ______________________

____

HOW DID YOU FIND OUT THAT YOU HAVE SCOLIOSIS? ______________________

____

ARE YOU EXPERIENCING ANY BACK PAIN? ________ **WHEN?** ______________________

____

HAVE YOU EVER HAD ANY X-RAYS TAKEN OF YOUR BACK? ________ **WHEN?** ______________________

____

HAVE YOU EVER HAD ANY SURGERY ON YOUR BACK? ________ **WHEN?** ______________________
WHERE? ______________________

DO YOU PERFORM SPECIFIC BACK EXERCISES ON A REGULAR BASIS? ______________________

DO YOU HAVE ANY MEDICAL PROBLEMS? ________ **IF YES, PLEASE SPECIFY:** ______________________

____

ANY PREVIOUS SURGERIES? ______________________

DO YOU HAVE A FAMILY HISTORY OF SCOLIOSIS? ______________________

LIST ALL ALLERGIES: ______________________

IF YOU ARE A FEMALE APPROXIMITELY WHEN DID YOUR MENSTRUAL CYCLE BEGIN?

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