

Name: \_\_\_\_\_  
DOB: \_\_\_\_\_  
Chart: \_\_\_\_\_  
Age: \_\_\_\_\_  
Date: \_\_\_\_\_

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## 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 APPROXIMATELY WHEN DID YOUR MENSTRUAL CYCLE BEGIN?  
\_\_\_\_\_