CONFIDENTIAL PATIENT INFORMATION

Patients Name (First) _____(M)_____(Last)_____

Address:_____
Street

City State Zip Code

Home Phone: _____-_____-_____ Work Phone:_____-_____-_____

D.O.B._____/_____/_____S.S. #: _____-_____-_____

Sex: M_____F_____ Patient Status: _____Single _____Married ____Other_____

Employed_____ Student_____

Employer/ School:_____ Phone: _____-_____-_____

Address: _____
Street City State Zip Code

Referring Physician:_____

Phone_____-_____-_____

Patient/ Parent Guardian Signature Date

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_____
SNEEZING____ WALKING____ LYING DOWN____ STANDING____ STRAINING AT STOOL_____

Please check the following activities that relieve your condition:
BENDING____ REACHING____ COUGHING____ SITTING____ TURNING HEAD____ LIFTING_____
SNEEZING____ 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_____
Face Flushed_____
Fainting_____
Fever_____
Head seems to heavy_____
Headaches_____
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_____
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

Gastrointestinal System

S	M	F	
____	____	____	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

S	M	F	
____	____	____	Excessive Thirst
____	____	____	Frequent Nausea
____	____	____	Vomiting
____	____	____	Diarrhea
____	____	____	Constipation
____	____	____	Hemorrhoids
____	____	____	Liver Problems
____	____	____	Gall Bladder Problems
____	____	____	Weight Trouble

Nervous System

S	M	F	
____	____	____	Fatigue
____	____	____	Allergies
____	____	____	Loss of Sleep
____	____	____	Fever
____	____	____	Tension Headaches
____	____	____	Migraine Headaches
____	____	____	Sinus Headaches

Genito-Urinary System

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

Ear, Eyes, Nose, & Throat

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

Male/ Female

S	M	F	
____	____	____	Menstrual Irregularity
____	____	____	Menstrual Cramping
____	____	____	Vaginal Pain/ Infections
____	____	____	Breast Pain/ Lumps
____	____	____	Prostate/ Sexual Dysfunction

Cardiovascular/ Respiratory

S	M	F	
____	____	____	Chest Pain
____	____	____	Short Breath
____	____	____	Blood Pressure Problems
____	____	____	Irregular Heartbeat
____	____	____	Heart Problems
____	____	____	Lung Problems/ Congestion
____	____	____	Varicose Veins
____	____	____	Ankle Swelling
____	____	____	Stroke

Diseases

S	M	F	
____	____	____	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_____

Health Questionnaire

1. What are your goals: ❑Weight loss ❑Fitness ❑Anti-aging ❑Better quality of sleep ❑Joint health ❑Mental clarity

2. Are you concerned with the amount of toxins and chemicals in your environment? No Yes

3. Are you concerned about your blood glucose levels? No Yes

4. Are you concerned about your bone density? No Yes

5. Would you like to increase your muscle mass? No Yes

6. Do you feel you get enough nutrition from the food you currently eat? No Yes

7. Do you eat organic produce? No Yes

8. Do you currently get a sound 8 hours sleep per night? No Yes

9. Do you feel alert every morning when you wake up? No Yes

10. Do you have a hard time losing weight? No Yes

11. Do you consume coffee, tea, sugar, candy or similar products to give you a boost during the day? No Yes

12. Do you take vitamins and minerals currently? No Yes List: _____
_____

If you would like to find out how to improve your internal body environment, we are considering offering our patients free lectures. Would you be interested in our contacting you when these lectures are scheduled? No Yes

PLEASE PRINT

Name_____Date_____