

Scoliosis 3DC

3 Baldwin Green Common, Suite 204, Woburn, MA 01801

CONFIDENTIAL PATIENT INFORMATION

Patient Name		Date	
Address	City	State	Zip
H#	W#	C#	Email
D.O.B	Age	Occupation	Marital Status <input type="checkbox"/> M <input type="checkbox"/> S <input type="checkbox"/> D <input type="checkbox"/> W
Family History of Scoliosis? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Parents <input type="checkbox"/> Siblings <input type="checkbox"/> Children			
Adolescent Pt: Parents: <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> W -Mom:		Dad:	
Mom email:		Dad email:	

SCOLIOSIS HISTORY

Date initially diagnosed:	Age:	Curve Type/Degree:
Health at onset of scoliosis		
Current/Most Recent X-ray & Result:	Pulmonary Testing?	
Scoliosis related concerns-please provide details...		
<input type="checkbox"/> Pain - location		
<input type="checkbox"/> Stiffness		
<input type="checkbox"/> Respiratory Problems		
<input type="checkbox"/> Fatigue		
<input type="checkbox"/> Unlevel shoulders/hips		
<input type="checkbox"/> Other, describe		
Do you have osteoporosis? <input type="checkbox"/> Y <input type="checkbox"/> N Healthcare practitioners seen? List		
<input type="checkbox"/> Exercise-type and frequency		<input type="checkbox"/> Pilates <input type="checkbox"/> Yoga <input type="checkbox"/> Rolfing

GENERAL MEDICAL

Medical History	
Medications, please list	
Surgeries/Fractures	
<input type="checkbox"/> Headaches <input type="checkbox"/> Neck Pain <input type="checkbox"/> Back Pain <input type="checkbox"/> Arm/Shoulder Pain <input type="checkbox"/> Hip/Leg Pain <input type="checkbox"/> Abdominal Pain	
<input type="checkbox"/> Chest Pain <input type="checkbox"/> Heart Trouble <input type="checkbox"/> High/Low Blood Pressure <input type="checkbox"/> Kidney Problems <input type="checkbox"/> Bladder Problem	
<input type="checkbox"/> Asthma <input type="checkbox"/> Diabetes <input type="checkbox"/> Dizziness <input type="checkbox"/> Depression <input type="checkbox"/> Fatigue <input type="checkbox"/> Anemia <input type="checkbox"/> Other	
Patient Signature:	Date:
Guardian Signature:	Date: