SCOLIOSIS FORM

LONG ISLAND SPINE SPECIALISTS

DATE: _____

LAST NAME: _____ FIRST NAME: _____ SOCIAL SECURITY#: _____

1. When was the spinal curvature first noted? _____
2. Who first noticed the curvature? _____
3. Has the curve gotten worse over time? No ☐ Yes ☐
4. What sort of treatment have you had to date? None ☐ (bracing, therapy, surgery, etc.) _____

   _____
5. If you have had scoliosis surgery, when, where, and who performed the procedure? _____

   _____
6. Is there pain in your back? If so, where is the pain and when do you feel it? _____

   _____

   Is there any weakness in your legs No ☐ Yes ☐

   (If you have no pain or weakness, please skip to question 9).
7. What makes your pain worse? Sitting ☐ Standing ☐ Walking ☐ Bending Forward ☐ Bending Backward ☐

   Coughing ☐ Sneezing ☐ Nothing ☐
8. What reduces your pain? Sitting ☐ Standing ☐ Walking ☐ Medication ☐ Exercise ☐ Lying Down ☐
9. What diagnostic tests have you had? X-rays ☐ MRI ☐ Myelogram ☐ CT scan ☐ Discogram ☐ Bone Scan ☐

   None ☐
10. For Girls/Women - Have you started menses (menstrual cycles) No ☐ Yes ☐

    If Yes, Age when started? _____ Have they been regular? _____
11. Students: Please state your school and grade? _____
12. Are you working? ☐ No ☐ Yes - Occupation: _____

    How many days, if any, have you missed from work or school in the past year due to your back pain?

    _____
13. **Do You Smoke?** ☐ No ☐ Yes If Yes - How Much? _____packs per day. For How Long? _____years.
14. **Do You Drink Alcoholic Beverages?** ☐ No ☐ Yes **Do you now, or have you ever taken illicit drugs?** ☐ No ☐ Yes
15. Is There A Family History of Scoliosis? ☐ No ☐ Yes If so, who? _____
16. How tall is your biological Mother? _____ Father? _____

    Siblings (Age and Height) _____

17. What other medical problems do you have, or have you had?

☐ Asthma ☐ Ulcers ☐ Other _____

☐ Arthritis ☐ Kidney Disease _____

☐ Angina ☐ Liver Disease _____

☐ High Blood Pressure ☐ Hepatitis

☐ Stroke ☐ Diabetes

☐ Spina Bifida ☐ Tuberculosis

☐ Cerebral Palsy ☐ Muscular Dystrophy

Neurologic Disease - No ☐ Yes ☐ If Yes, What Type? _____

18. Please list any surgery, other than **scoliosis surgery**, that you have had: _____

_____

19. Please List Any Medication You Are Taking At This Time. _____

_____

_____

_____

20. Do You Have Any Allergies To Medication? ☐ No ☐ Yes If yes, please list medications below.

_____

_____

_____

Latex Allergy ☐

Contact Information:

PARENT/GUARDIAN -SIGNATURE: _____ **DATE** _____

PLEASE PRINT NAME: _____ **PHONE** _____

Thank You