SCOLIOSIS HISTORY FORM

NAME____ TODAY'S DATE _________________________

AGE_________ SEX_________ HEIGHT_________ WEIGHT_________

AGE THAT PERIODS (MENSTRATION) STARTED (IF FEMALE)____

AGE AT DIAGNOSIS OF ANY SCOLIOSIS ____

PLEASE LIST TREATMENT TO DATE, IF ANY ____

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FAMILY HISTORY OF SCOLIOSIS (LIST MOTHER, FATHER, BROTHER, SISTER, RELATIVES WHO MIGHT HAVE SCOLIOSIS): ____

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WHAT PROBLEMS ARE YOU HAVING WITH YOUR BACK AT THIS TIME? ____________________________________

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HAVE YOU LOST ANY HEIGHT THAT YOU ARE AWARE OF? ____

DO YOU HAVE ANY SHORTNESS OF BREATH OR TROUBLE BREATHING? ___________________________________

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WHAT OTHER PROBLEMS OR CONCERNS DO YOU HAVE REGARDING YOUR SCOLIOSIS? ______________________

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PLEASE LIST DIFFICULTIES WITH FITTING OF CLOTHES, PERSONAL APPEARANCE AND OTHER COSMETIC CONCERNS: ____

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COMMENTS: