Scoliosis AZ Centers

Adult - New Patient Questionnaire

Today's Date: Please COMPLETE FULLY. Thank you.

Last Name Initial First Name	Home #
Address City / Postal Code	Work # Cell #
Male Female Date of Birth (MM/DD/YY) Age Now	Email
Name of Spouse or Significant Other: Number of Children:	

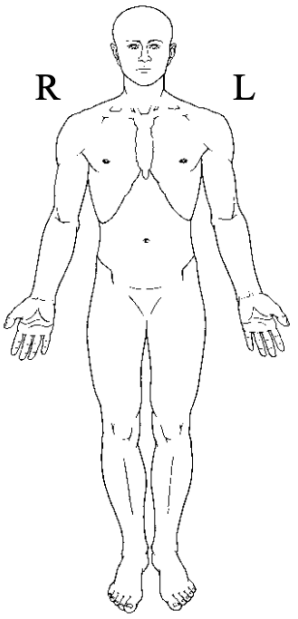
Family Doctor Specialist(s)
How did you hear about our office?

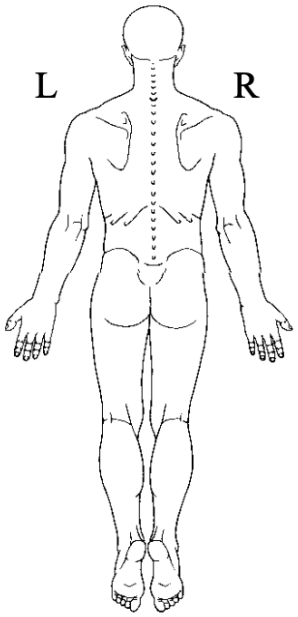
Age when scoliosis or kyphosis was noticed? Has it gotten BETTER WORSE stayed the SAME	Height Weight Weight changed 10 lbs or more in the last year? Y / N

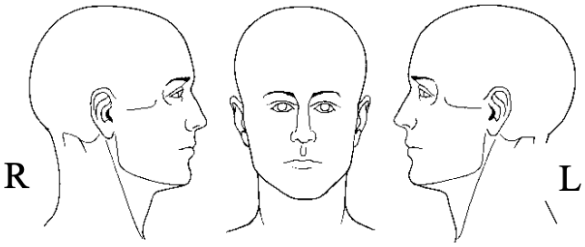
Have X-rays been taken? If so, please list when and where they were taken
Please list any MEDICATIONS being taken or SURGERIES that have been done
Please list any dietary SUPPLEMENTS taken (e.g. vitamins and minerals)
Please describe any ACCIDENTS or OTHER INJURIES that have occurred
Please describe SPORTS, RECREATION, and EXERCISE HABITS

Please draw the location of any symptoms you may have on the body outline below, using the appropriate symbol(s).

Ache	Burning	Numbness	Pins and Needles	Stabbing	Stiff and Tight	Shooting Pain
AAA	BBB	NNN	+++	///	222	↓ ↓ ↓







Please CHECK anything that applies to you now, or CIRCLE anything that applied in the past.

GENERAL:

- □ Cancer
- □ Unexplained weight change
- □ Stroke
- □ High blood pressure
- □ Diabetes
- □ Osteoporosis

NECK:

- □ Neck pain
- □ Stiff neck and shoulders
- □ Numbness or tingling in: shoulders, arms or hands
- □ Headaches
- □ Dizziness or balance problems
- □ Visual problems
- □ Weakness in grip
- □ Jaw problems
- □ Sinus problems
- □ Low energy or fatigue
- □ Thyroid problems

MID-BACK:

- □ Mid-back pain
- □ Heart problems
- □ Stomach problems
- □ Rib problems
- □ Difficulty or pain with breathing
- □ Indigestion or heartburn
- □ Lung problems
- □ Recurrent lung infections
- □ Asthma, allergies, or wheezing

LOW-BACK:

- □ Low-back pain
- □ Stiff low-back
- □ Numbness or tingling in: bum, legs, or feet
- □ Sciatica
- □ Muscle cramps in legs or feet
- □ Weakness in back or legs
- □ Constipation or diarrhea
- □ Painful or irregular menstrual cycle
- □ Sexual dysfunction
- □ Frequent or difficult urination

Have any of your BLOOD RELATIVES had any diseases or significant health concerns?
If so, please describe below. (M=Mother F=Father B= Brother S=Sister G=Grandparents)

Family History of Scoliosis:

	YES	NO
Mother:		
Father:		
Other Relatives:		

If yes, please provide details: _____

_____

_____

Do you have:

	YES	NO
Cardiac problems:		
Visual problems (besides corrective lenses)		

Have you ever had:

	YES	NO
Orthodontics (braces):		
Chiropractic:		
Physiotherapy:		
Massage Therapy:		
Other Therapeutic Body Work:		

For FEMALES:

	YES	NO
Reached onset of MENARCHE:		
If so, having IRREGULAR periods:		
having REGULAR periods:		
PERI/POST MENOPAUSAL:		

Age when FIRST PERIOD occured:

For MALES:

	YES	NO
VOICE has changed Partially:		
Fully:		

Age when VOICE started to change:

Have you ever had Spinal Surgery?

If so, please provide details: _____

_____

_____

Have you ever worn a Spine Brace?

If so, please provide details: _____

_____

_____