673 Berkmar Circle
Charlottesville, VA 22901
(434) 566-0126

Patient Name ________________________________

Date ________________________________

Part One: Medical History

When was the scoliosis first diagnosed, and by whom____

____

How was it treated?

____

____

Please list the names of the physicians and/or clinics who treated you:___________________________

____

Please list any family members with scoliosis, how they were treated, and who they were treated by:

____

____

List any incidents of trauma, including complications at birth such as Caesarean delivery:

____

____

What was the Cobb angle when you were first diagnosed? ______________________________________

Did the Cobb angle change after treatment? If yes, to what? ___________________________________

When was your last x-ray, and what was the Cobb angle? _____________________________________

What are you doing currently to treat your scoliosis? ____

____

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Part Two: Social & Occupational History

Please list the hobbies and activities you enjoy on a regular basis: ________________________________

____

____

____

Do any of these activities involve repetitive impacts or shocks? ________________________________

What activities require you to perform any sort of repetitive motion? ________________________________

____

____

Do you keep a written diary? ____

How many hours daily do you spend doing the following activities:

Using a laptop computer? ________ Studying at a desk? _______ Watching television? _______

Using a hand-held mobile device ______ Playing video games? ______ Writing in a journal?_________

Do you have any friends or family members who are unaware of your scoliosis? If so, would it matter to you if they found out? ____

What is your primary motivation in wanting to correct your scoliosis?

____

____

____

____

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Part Three: Nutritional History

How many cans of soda pop do you consume daily? _____ Diet or regular? _________________________________

How often do you consume citrus fruits or juices? How many per day or week? ______________________________

How many glasses of water do you drink each day? ____

Do you drink milk or soy milk? _______ Dairy or soy products? ____

How many times do you eat out at fast-food restaurants each week? ____

Are artificial sweeteners (such as Splenda, NutriSweet, sucralose, etc.) or MSG a regular part of your diet? ________

How often do you eat fresh fruits & vegetables? ____

How often do you eat grains, granola, cereals or bread-type products? Which ones do you consume? ____________

____

What are your favorite foods? ____

____

____

Are you currently taking any vitamins or nutritional supplements? If so, which ones?

____

____

Do you take any prescription or non-prescription medication on a regular basis? If so, which ones?

____

____

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