Adventist Health | Northern California Spine Institute

PEDIATRIC SCOLIOSIS/KYPHOSIS PATIENT QUESTIONNAIRE

This is a questionnaire for your completion. Please fill out the form completely and neatly.
If you have any questions, please ask the nurse. Thank you for your cooperation.

DATE: _____

PATIENT NAME: _____ Birthdate: _____

Age (years + months): _____

1. Past medical problems: _____

   _____

   _____

2. List any significant illnesses that run in your family: _____

   _____

   _____

3. Smoker? No Yes, ___ packs per day for _____year(s). Daily alcohol: _____
4. List past surgical procedures and dates: _____

   _____

   _____

5. Current medications taken on a regular basis: _____

   _____

6. Approximate height: _____ and weight: _____
7. Approximate growth in the last visit and months: _____

8. Height of mother: _____

9. Height of father: _____

10. Height of siblings: _____

11. How was scoliosis/kyphosis discovered? _____

_____

12. Previous treatment for scoliosis/kyphosis: _____

_____

13. Have menses/periods begun? No Yes Approximate date when begun: _____

Are they regular? No Yes

14. Do you know your present curve measurement? _____

15. Latest x-ray, date and location: _____

16. Do you have any spinal pain? If so, describe: _____

_____

17. Do you have weakness/numbness in legs? If so, where is weakness? _____

Where is numbness? _____

18. Do you have difficulty with control of bowel/bladder? If so, describe: _____

_____

19. Referring physician or primary care physician, address and phone #: _____

_____

20. Pediatrician, address and phone #: _____

_____

21. Previous physicians seen for treatment of scoliosis/kyphosis: _____

_____