CLEAR Scoliosis Center

ST. CLOUD ■ MINNESOTA

Patient Name _____ Date _____

Please take the time to fill out this form in detail. Do not leave any questions blank. If you need assistance, please contact the primary doctor or a member of our staff. If additional space is needed to answer a question, please let us know and we will provide you with a separate sheet of paper. Your time is very valuable, and greatly appreciated!

Part One: Medical History

When was the scoliosis first diagnosed, and by whom? _____

_____

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

How was it treated? _____

_____

_____

Please list the names of the physicians and/or clinics who treated you, and the timeframe of treatment (how long did the treatment last): _____

_____

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

Were there any side-effects or negative consequences of the treatment? If yes, what were they? _____

_____

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: _____

_____

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

What are you doing currently to treat your scoliosis? _____

_____

Are you currently experiencing any health issues which you feel are related to your scoliosis? If yes, please describe them. _____

_____

_____

Please list any past surgeries: _____

_____

_____

Female Patients only:

When was the onset of your first menses? _____

How many pregnancies have you had? _____

When was the onset of menopause? _____

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? _____

Do any activities that you do on a regular basis require you to perform any sort of repetitive motion? If so, please describe the activity. _____

_____

_____

Do you keep a written diary? _____

How many hours daily do you spend on a laptop computer? _____ Desktop? _____

Studying at a desk? _____ Watching television? _____

Playing video games? _____ Writing or reading? _____

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? _____

_____

_____

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 glasses of water do you drink each day? _____

Do you drink milk or soy milk?_____ Do you eat dairy, yogurt or soy products? _____

_____

How many times do you eat out at fast-food restaurant each week? _____

Are artificial sweeteners (such as Splenda, NutriSweet, sucralose, etc.) or MSG

(Accent) a regular part of your diet? _____

How often do you eat fresh fruits & vegetables? _____

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? _____