

# The Advanced Spine Center

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For Office Use Only:

HR: \_\_\_\_\_

BP: \_\_\_\_\_/\_\_\_\_\_

## PEDIATRIC SPINE HISTORY

Name of Patient: \_\_\_\_\_

Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Height: \_\_\_\_\_ ft \_\_\_\_\_ in

Weight: \_\_\_\_\_ lbs

Form Completed By: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Referring Doctor Name and Address: \_\_\_\_\_

What problem is the doctor seeing the patient for today? (Check all that apply)

- Spinal Deformity:     Scoliosis     Kyphosis     Spondylolisthesis  
Pain:                     Neck Pain                    Arm:     Pain     Numbness     Weakness  
                               Back Pain                    Leg:     Pain     Numbness     Weakness

Other (please describe): \_\_\_\_\_

How long has the pain/problem been present? \_\_\_\_\_

Was there an injury, and if so, what caused the injury? \_\_\_\_\_

How severe is the pain at the location described above (circle below):

0            1            2            3            4            5            6            7            8            9            10  
No pain            Slight            Mild            Moderate            Severe            Excruciating

Has the pain/problem worsened recently?     No     Yes, how recently? \_\_\_\_\_

Quality of the pain:     Sharp             Burning             Aching             Dull

What makes the problem better? \_\_\_\_\_ Worse? \_\_\_\_\_

Is the pain (check all that apply):     Continuous     Night pain     Activity related     Unpredictable

Does the patient have numbness or weakness in his/her arms or legs?     No     Yes

If yes, where? \_\_\_\_\_

Are there any problems with loss of bowel or bladder control?     No     Yes

Are there any problems with balance, fine motor control, or dexterity?     No     Yes

How was your spinal deformity discovered? \_\_\_\_\_

Do you know your present curve measurements? \_\_\_\_\_

Reasons for seeking treatment at this time:     progressive deformity     pain     can't stand straight  
 don't like the appearance of back/waistline     other: \_\_\_\_\_

Growth in the past six months: \_\_\_\_\_

Height of:            Mother \_\_\_\_\_            Father \_\_\_\_\_            Siblings \_\_\_\_\_

What treatments have you tried?

- |  |                                    |   |                                    |
|--|------------------------------------|---|------------------------------------|
| <input type="checkbox"/> Physical therapy/Exercise | <input type="checkbox"/> TENS unit | <input type="checkbox"/> Narcotic medications | <input type="checkbox"/> Braces    |
| <input type="checkbox"/> Massage/Ultrasound        | <input type="checkbox"/> Traction  | <input type="checkbox"/> Anti-Inflammatories  | <input type="checkbox"/> Orthotics |
| <input type="checkbox"/> Chiropractic treatment    | <input type="checkbox"/> Surgery   | <input type="checkbox"/> Steroid injections   | <input type="checkbox"/> Cast/boot |

If recommended, please rate how interested you are in having surgery to treat your problem:

0	1	2	3	4	5	6	7	8	9	10
Not at all		Maybe					Definitely			

Previous physicians seen for **this** problem:

<i>Physician</i>	<i>Specialty</i>	<i>City, State</i>	<i>Treatment</i>

Medications taken for **this** problem:

<i>Name of Medication</i>	<i>Dose</i>	<i>Reason</i>

X-rays and Tests for **this** problem:

	<i>Results</i>	<i>Date</i>	<i>Location</i>
<input type="checkbox"/> X-rays			
<input type="checkbox"/> MRI			
<input type="checkbox"/> CT scan			
<input type="checkbox"/> Bone scan			
<input type="checkbox"/> Other			

Because of this problem, have you filed or do you plan to file a lawsuit?       Yes    No

Is there any other information that the doctor should be aware of? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

# WHERE IS YOUR PAIN NOW?

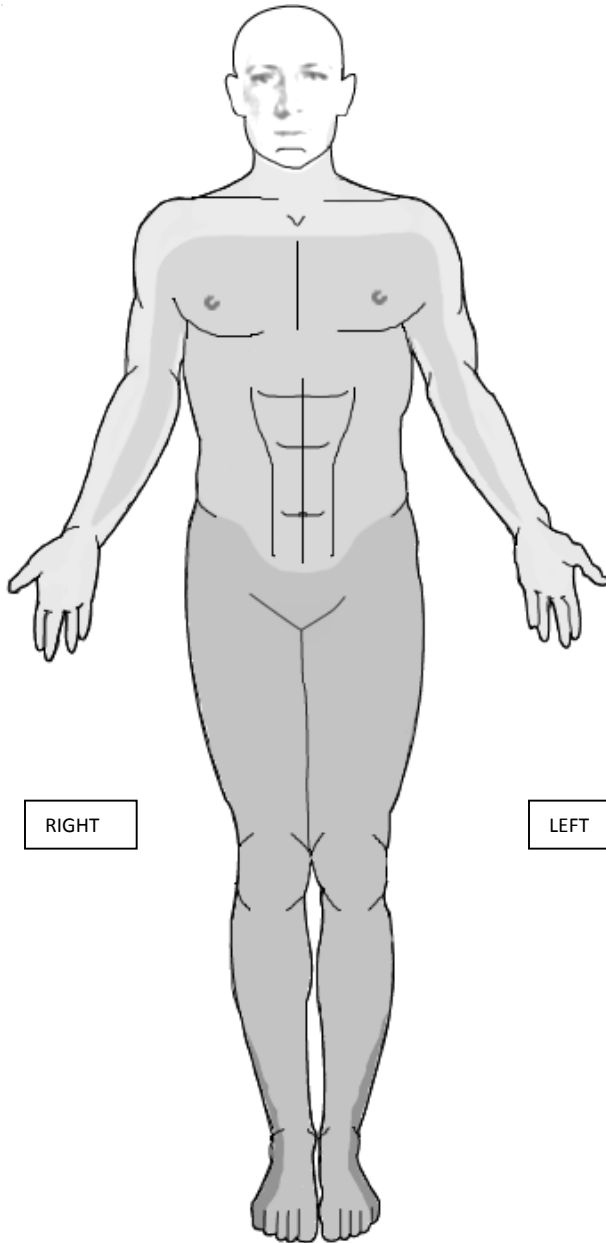
Using the appropriate symbols, mark all of the areas on your body where you feel the sensations described below

PAIN x x x x

BURNING + + + +

TINGLING - - -

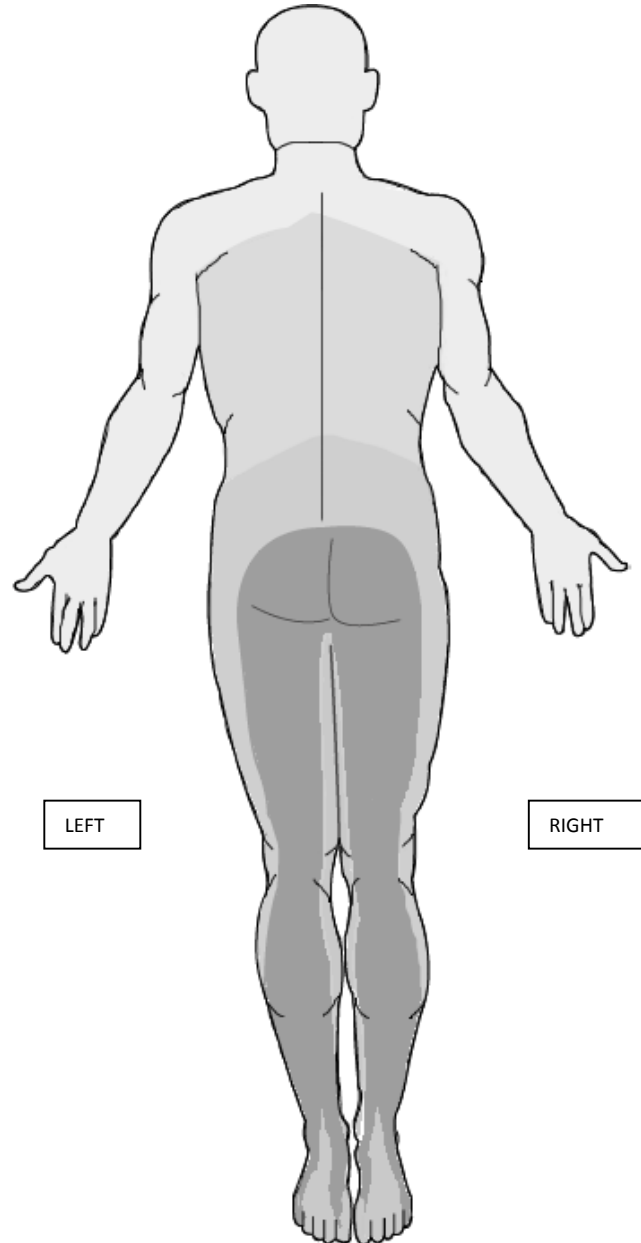
NUMBNESS o o o o



RIGHT

LEFT

**FRONT**



LEFT

RIGHT

**BACK**

My number one problem is:

\_\_\_ back/neck pain

\_\_\_ arm/leg pain

\_\_\_ numbness/tingling

\_\_\_ weakness

**PAST MEDICAL HISTORY: (check all that apply)**

None Apply

- Down's syndrome
- Muscular dystrophy
- Neurofibromatosis
- Rheumatoid arthritis
- Seizures
- Spina bifida or Myelodysplasia
- Genetic syndrome or chromosome disorder \_\_\_\_\_
- Other: \_\_\_\_\_
- Diabetes mellitus
- Bleeding/platelet disorder
- Cerebral palsy
- Hepatitis (A, B, or C)
- Asthma
- AD/HD
- Heart murmur
- Abnormal heartbeat
- Thyroid problems
- Rickets
- Lead poisoning
- Kidney problems
- HIV/AIDS

Are all immunizations up to date?  No  Yes

**Birth History:**

- Premature
- Full Term
- Vaginal delivery
- C-section
- Breech

Birth weight: \_\_\_\_\_ lbs \_\_\_\_\_ oz

Please explain any birth complications: \_\_\_\_\_

**Developmental History:**  Check here if the patient/your child has had no developmental delays

Did your child have any delays in the following:

- Rolling over
- Walking holding on to furniture
- Sitting independently
- Walking independently
- Standing independently
- Other: \_\_\_\_\_

Please explain any checked above: \_\_\_\_\_

**Menstrual History:**  N/A, child is male

Age at first menstrual period: \_\_\_\_\_ Date of last menstrual period: \_\_\_\_\_

Is there any chance that the patient could be pregnant?  No  Yes (\*\*Please let x-ray tech know\*\*)

**PAST SURGICAL HISTORY:**  No prior surgery

Operation	Date	Surgeon/Hospital

Has the patient/your child ever had general anesthesia?  No  Yes

If yes, any problems related to this?  No  Yes

Please explain any problems related to general anesthesia: \_\_\_\_\_

**MEDICATIONS: (prescribed and over the counter)**

Name of Medication	Dose	Reason

**ALLERGIES:**  None

Name of Medication	Reaction (rash, swelling, upset stomach, etc)

Are you allergic to:  Latex  Nickel

**SOCIAL HISTORY:**

Grade level in school: \_\_\_\_\_ School attended: \_\_\_\_\_

Child's parents/guardians are:  Married  Divorced  Separated  Not Married

Child lives with: \_\_\_\_\_

Sports played: \_\_\_\_\_

Number of brothers/sisters: \_\_\_\_\_

Is there smoking in the house? \_\_\_\_\_

Does the patient smoke?  No  Yes, number of packs per day: \_\_\_\_\_  Prior smoker

Does the patient drink alcohol?  No  Yes, how much/how often? \_\_\_\_\_

Any illegal drug use?  No  Yes

Who is the patient's primary care physician? \_\_\_\_\_

Address: \_\_\_\_\_

**FAMILY HISTORY: (check all that apply)**

No significant family history

- Scoliosis  Diabetes  Bleeding problems  Heart disease
- Low back pain  Perthes disease  Arthritis  Cancer
- Round back  Hip problems  High blood pressure  Vascular problems
- Other (please list): \_\_\_\_\_

**REVIEW OF SYSTEMS (check all that apply within the last 30 days):**  None

- Fever  Sleep apnea (snoring)  Nausea
- Chills  Cough  Vomiting
- Weight loss  Trouble swallowing  Diarrhea
- Weight gain  Seizures  Constipation
- Glasses/contacts  Palpitations  Skin rashes
- Vision changes  Seasonal allergies  Gastric reflux
- Urinary tract infection  Food allergies  ADHD
- Hearing loss  Ear pain
- Other: \_\_\_\_\_

I certify that the above is correct and complete to the best of my knowledge.

Patient's Signature: \_\_\_\_\_ Physician's Signature: \_\_\_\_\_