The Advanced Spine Center

Jason E. Lowenstein, MD
Jamie L. DiGraziano, PA-C

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

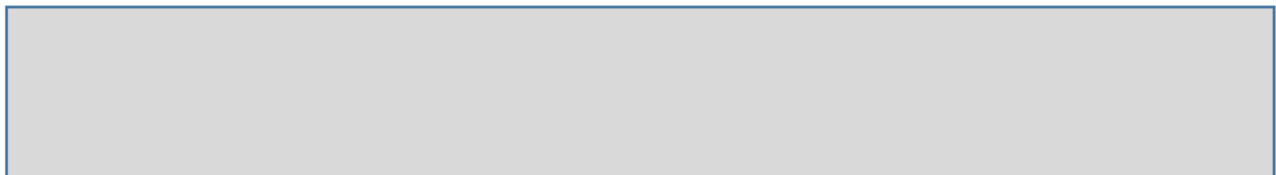
Are there any problems with balance, fine motor control, or dexterity? ❑ No ❑ Yes

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?

- ❑ Physical therapy/Exercise
- ❑ TENS unit
- ❑ Narcotic medications
- ❑ Braces
- ❑ Massage/Ultrasound
- ❑ Traction
- ❑ Anti-Inflammatories
- ❑ Orthotics
- ❑ Chiropractic treatment
- ❑ Surgery
- ❑ Steroid injections
- ❑ 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:

Physician	*Specialty*	*City, State*	*Treatment*

Medications taken for ***this*** problem:

Name of Medication	*Dose*	*Reason*

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

	Results	*Date*	*Location*
❑ X-rays			
❑ MRI			
❑ CT scan			
❑ Bone scan			
❑ 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? ________________________________

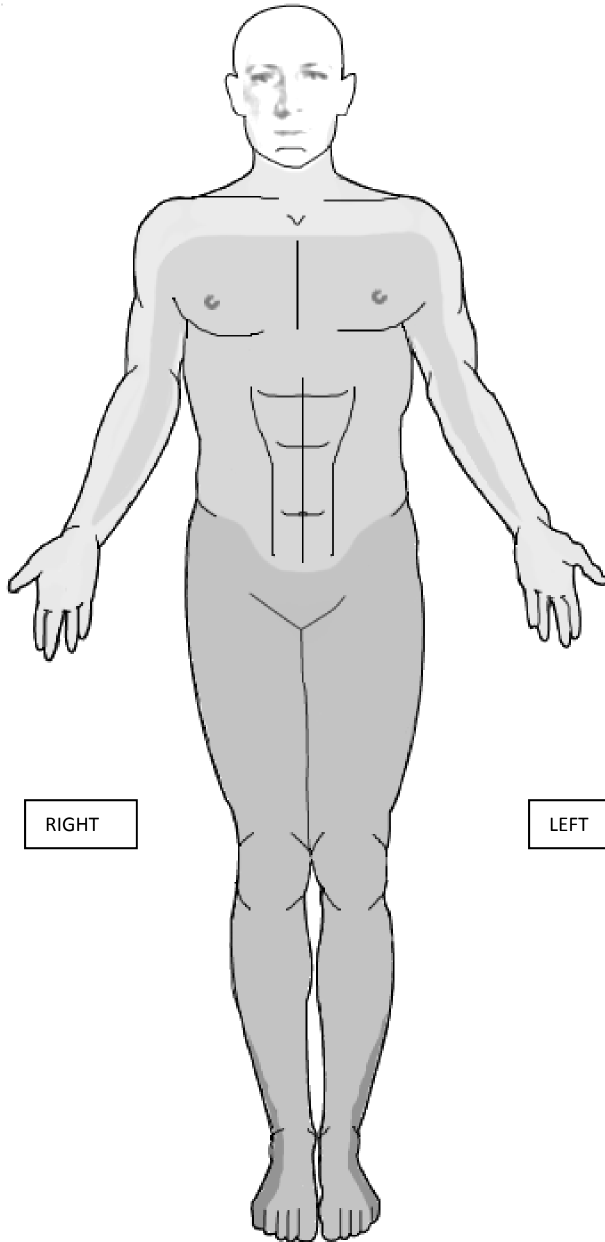
____

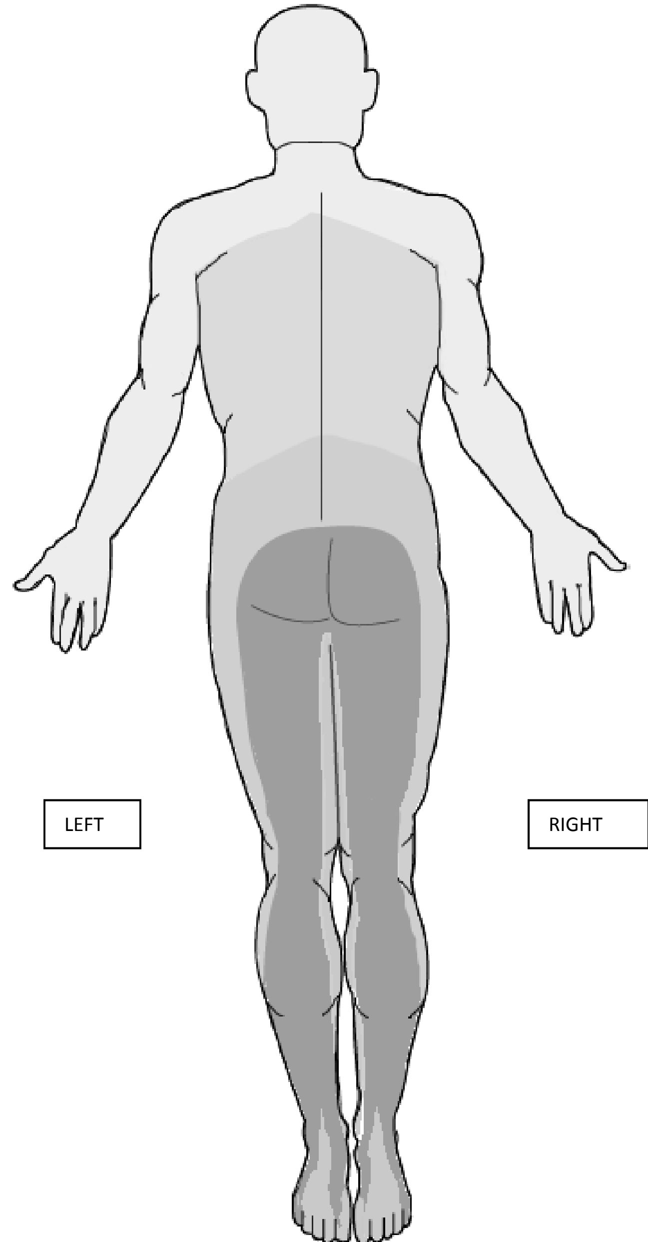
____

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





FRONT　　**BACK**

My number one problem is:

____ back/neck pain　____ arm/leg pain　____ numbness/tingling　____ weakness

PAST MEDICAL HISTORY: (check all that apply) ❑ *None Apply*

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

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 ❑ Sitting independently ❑ Standing independently
❑ Walking holding on to furniture ❑ Walking 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*

<u>ALLERGIES</u>: ❑ *None*

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

Are you allergic to: ❑ Latex ❑ Nickel

<u>SOCIAL HISTORY</u>:

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: ____

<u>FAMILY HISTORY</u>: (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): ____

<u>REVIEW OF SYSTEMS</u> (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: ______________________