INSTITUTE FOR SPINE & SCOLIOSIS, PA
The Leader in Less Invasive & Complex Spine Surgery

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Pediatric Patient Questionnaire

Dear Parent,

Thank you for choosing The Institute for Spine & Scoliosis to help your child. This is a health questionnaire for your child (18 years or younger). ***Please complete this form and bring it with you at the time of your first appointment with us***. *Please bring recent and prior X-rays (CD preferred), reports, and any back braces. **Please feel free to ask the doctor as many questions as you need to help understand our evaluation and recommendations for your child's back. (Bringing a list of questions is often helpful.)

Date Completed ___ / ____ / ____ **Person Completing This Form** _____

Patient's Name _____

Date of Birth ___ / ____ / ____

Reason For Consultation Today: _____

When was it first noticed? ___ / ____ / ___

By whom? (circle) Parent I PCP I School Nurse I Friend I Other _____

Name of Doctor/Practitioner Following This Condition:_____

Date of First X-rays ___ / ____ / ___

Please Include Results (curve degree, condition, etc)_____

Spine MRI (circle) YES NO PENDING **If Yes, Do You Have CD?** YES NO **Report?** YES NO

For Scoliosis, if available please list dates and degrees of the curves from prior X-rays.

Date of X-ray	***Thoracic (Upper Spine)***	***Lumbar (Lower Spine)***
___ / ____ / _____	_____	_____
___ / ____ / _____	_____	_____
___ / ____ / _____	_____	_____

NAME:

Do you have back pain ? YES NO

Please describe:_____

_____

Current Treatments: *please check and then circle all that apply*

- ☐ None
- ☐ Brace type: _____ hrs/day _____ Date Started ___ / ____ / ___ Still Fits? YES NO
- ☐ Therapy (Shroth, PT Stretching, Pilates, Yoga, Gym, Other_____)
- ☐ Chiropractic (ScoliSmart, Activity suit, CLEAR, adjustments, Other_____)
- ☐ Home exercises (Stretching, Strengthening, Resistance Bands, Other_____)
- ☐ Medication (Pain, Muscle Relaxants, Other_____)
- ☐ Supplements (Prescribed or Self)

Previous Treatments: *please check and then circle all that apply*

- ☐ None
- ☐ Brace type: _____ hrs/day_____ Date Stopped ___ / ____ / ___ Why?_____
- ☐ Therapy (Shroth, PT Stretching, Pilates, Yoga, Gym, Other_____)
- ☐ Chiropractic (ScoliSmart, Activity suit, CLEAR, adjustments, Other_____)
- ☐ Home exercises (Stretching, Strengthening, Resistance Bands, Home Equipment, Other_____)
- ☐ Medication (Pain, Muscle Relaxants, Other_____)
- ☐ Supplements (Prescribed or Self)
- ☐ Surgery:_____

Past Medical History

Has Your Child Had

a. **Hospitalizations**? YES NO
If yes, what illness? What age?

_____

b. **Surgeries**? YES NO
If yes, for what? What age?

_____

c. **Other Serious Medical Illnesses**? YES NO
If yes, what kind?

_____

d. **Reactions To Any Drug (Allergy)**? YES NO
If yes, please explain:

_____

e. **Is Your Child Currently Taking Medications, Vitamins, Or Supplements**? YES NO

Medication, Vitamin, or Supplement	Dose	How Often?

f. **Were There Any Problems During The Delivery Or Pregnancy Of This Child**? YES NO

If yes, please explain.

_____

_____

g. **Has Your Child Ever Or Does Your Child Now Receive Any Therapies**? YES NO

If yes please explain:

_____

_____

FAMILY HISTORY

1. **Mother** Name_____ Age ___ Occupation_____

2. **Father/ Partner** Name_____ Age ___ Occupation_____

3. **Marital Status of Parents**: *(circle)* Married Separated Divorced Never Married Other_____

4. **Other Children in Family**

Dates Of Birth	Name	Health Concerns?
___ / ____ / ___		
___ / ____ / ___		
___ / ____ / ___		
___ / ____ / ___		
___ / ____ / ___		
___ / ____ / ___		

5. **Are There Cultural Or Religious Practices That Might Affect Your Child'S Medical Care**? YES NO

If yes, please explain: (examples: blood transfusion, dietary rules):

_____

_____

6. **Is There A History In The Family/ Blood Relative With**?

- Scoliosis YES NO (If yes, please include who and what treatment received below)

_____

_____

- Kyphosis (hunchback) YES NO
- Degenerative disc disease YES NO
- Connective tissue disease (Marfans, Ehlers- Danlos, NF) YES NO
- Birth defects, genetic defects YES NO

SOCIAL HISTORY

Current grade level in school? _____

Sports/Activities?_____

Smoke? YES NO

Any difficulty sleeping at night? YES NO

REVIEW OF SYMPTOMS

(*Please **circle all that apply** and make notes as needed. Circle **none** if there are no symptoms/concerns)*

Head: headaches, concussions, other, none

Eyes: visual changes, tendency to cross, discharge, redness, puffiness, glasses, other, none

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Ears: difficulty with hearing, pain, ear infections, ear tubes, other, none

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Nose: discharge, difficulty breathing through nose, bleeding, sleep apnea, none

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Mouth and throat: chronic sore throat, trouble swallowing, teeth problems, other, none

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Neck: swollen glands, stiffness, other, none

Chest: pain, lumps, indentation of breast bone, other, none

Lungs: short of breath, can't keep up with peers, cough, hoarseness, wheezing, other, none

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Heart: Heart murmurs or heart "trouble", turning blue with activity, other, none

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Gastrointestinal: poor appetite, vomiting, abdominal pain, constipation, diarrhea, other, none

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Genitourinary: pain or blood with urination, increased frequency, bed wetting, other, none

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For Females: Had First Period Yet? YES NO If Yes, When ___ / ____ / ___

Extremities: weakness, numb/tingling, color changes, joint pains, swelling, very flexible joints, difficulty walking, other, none

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Neurologic: Seizures, headaches, fainting, dizziness, incoordination, other, none

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Skin: eczema, rashes, hives, easy bruising or bleeding, birth marks, lumps, scars, other, none

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Behavioral: attention difficulties, anxiety, depression, trouble sleeping, problems in school, history of psychiatric problems, other, none

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