

**PATIENT INFORMATION**

Date \_\_\_\_\_  
Name \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ SS# \_\_\_\_\_  
Birth Date \_\_\_/\_\_\_/\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_  
 Married  Single  Divorced  Widowed  
Whom may we thank for referring you? \_\_\_\_\_  
What name do you prefer to be called? \_\_\_\_\_  
May we use your email for discounts and other special email-only offers? Yes No  
Email \_\_\_\_\_

**EMPLOYMENT INFO**

Occupation \_\_\_\_\_  
Employer \_\_\_\_\_  
Address \_\_\_\_\_  
Phone # \_\_\_\_\_

**INSURED INFO**

Insured Name \_\_\_\_\_  
Relationship \_\_\_\_\_  
DOB \_\_\_\_\_

Who is responsible for your bill, You and:

Spouse  Health Insurance  Workers' Comp.  Auto Insurance  Medicare

Previous scoliosis care:  None  Type of care & approximate date of last visit \_\_\_\_\_

**CURRENT HEALTH CONDITION**

Date Scoliosis First Diagnosed: \_\_\_\_\_ Physician Who Diagnosed: \_\_\_\_\_

Family With Scoliosis? Y / N If yes, who? \_\_\_\_\_ [Mark your areas of pain on figure]

Have you already had x-rays?  Yes  No

If yes, what was the Cobb angle measurement? \_\_\_\_\_

Do you currently have pain? Y / N

Where? \_\_\_\_\_

How would you describe the pain?

Sharp  Dull  Aching  Burning  Numb  
 Throbbing  Radiating  Deep  Other \_\_\_\_\_

Rate the pain on a scale of 1-10 (10 being unbearable pain):

Right Now 1---2---3---4---5---6---7---8---9---10

At Its Worst 1---2---3---4---5---6---7---8---9---10

Have You Seen Other Doctors For Treatment?  Yes  No

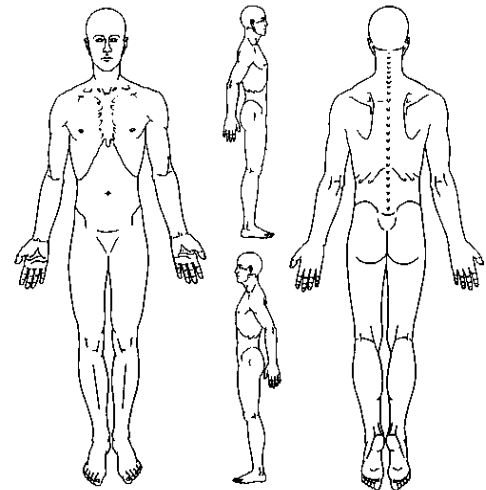
Who? \_\_\_\_\_

Type of treatment? \_\_\_\_\_ Results? \_\_\_\_\_

Do you wear a shoe lift?  Yes  No

Do you suffer from any condition that is directly causing your scoliosis? (i.e. syringomyelia, connective tissue disorder, cerebral palsy)

\_\_\_\_\_  
\_\_\_\_\_



Below is a list of diseases that may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of care.

**CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD**

- |                                    |                                    |                                   |   |  |
|------------------------------------|------------------------------------|-----------------------------------|---|--|
| <input type="checkbox"/> AIDS /HIV | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Gout               | <input type="checkbox"/> Osteoporosis    |
| <input type="checkbox"/> Anemia    | <input type="checkbox"/> Cancer    | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Rheumatic Fever |

**CHECK ANY YOU HAVE HAD IN THE PAST 6 MONTHS**

**Musculoskeletal Code**

- General Stiffness
- General Weakness
- Swollen Joints
- Spinal Curvature
- Neck Pain
- Arm Pain
- Pain Between Shoulders
- Low Back Pain
- Foot Trouble
- Walking Problems
- Jaw Problems

**Nervous System Code**

- Nervous
- Numbness
- Dizziness
- Forgetfulness
- Depression
- Cold/Tingling Extremities
- Stress
- Twitching

**General Code**

- Fatigue
- Allergies
- Headache
- Loss of Sleep
- Weight Loss
- Fever
- Thyroid Problems

**Gastrointestinal Code**

- Poor/Excessive Appetite
- Excessive Thirst
- Vomiting
- Nausea
- Diarrhea
- Constipation
- Liver Problems
- Gall Bladder Problems
- Abdominal Cramps
- Gas/Bloating/Belching
- Heartburn
- Black/Bloody Stools
- Colitis

**C-V-R Code**

- Chest Pain
- Short Breath
- Asthma
- Blood Pressure Problems
- Irregular Heartbeat
- Heart Problems
- Lung Problems
- Varicose Veins
- Ankle Swelling
- Stroke

**EENT Code**

- Vision Problems
- Dental Problems
- Sore Throat
- Ear Aches
- Hearing Difficulty
- Stuffed Nose
- Frequent Colds
- Nose Bleeds
- Sinus Trouble
- Hoarseness

**Genitourinary Code**

- Bladder Trouble
- Painful/Excessive Urine
- Discolored Urine

**For Women Only**

- Cramps
- Irregular Cycle
- Painful Periods
- Pregnant (now)

**Family History**

The following members have a same or similar problem as I do:

- Father
- Mother
- Brother
- Sister
- Child
- Other \_\_\_\_\_

**HEALTH HABITS**

*Exercise/Sports/Hobbies:*

- 1) Type \_\_\_\_\_ Frequency \_\_\_\_\_      2) Type \_\_\_\_\_ Frequency \_\_\_\_\_  
 3) Type \_\_\_\_\_ Frequency \_\_\_\_\_      4) Type \_\_\_\_\_ Frequency \_\_\_\_\_

*Sleep:* Hours/night \_\_\_\_ Sleep quality \_\_\_\_\_ Do you sleep on your:  Back  Side  Stomach

*Smoking/Drinking/Diet:* (how much and how often)

Tea/Coffee \_\_\_\_\_ Liquor/Beer \_\_\_\_\_ Cigarettes/Tobacco \_\_\_\_\_

**OCCUPATIONAL INFORMATION**

Job involves:  Sitting  Standing How long? \_\_\_\_\_

Bending  Stooping  Twisting  Turning  Lifting - How much weight? \_\_\_\_\_

Physical activity at work:  Sedentary  Light manual labor  Heavy labor

Do any work activities aggravate your complaints? \_\_\_\_\_

**Please list ALL previous accidents and falls**

What \_\_\_\_\_ When \_\_\_\_\_

What \_\_\_\_\_ When \_\_\_\_\_

What \_\_\_\_\_ When \_\_\_\_\_

**Please list ALL medications and/or vitamins you take**

Name \_\_\_\_\_ For What \_\_\_\_\_ Name \_\_\_\_\_ For What \_\_\_\_\_  
Name \_\_\_\_\_ For What \_\_\_\_\_ Name \_\_\_\_\_ For What \_\_\_\_\_  
Name \_\_\_\_\_ For What \_\_\_\_\_ Name \_\_\_\_\_ For What \_\_\_\_\_

**Please list ALL surgeries, hospitalizations, fractures/dislocations you have had**

Type \_\_\_\_\_ When \_\_\_\_\_  
Type \_\_\_\_\_ When \_\_\_\_\_  
Type \_\_\_\_\_ When \_\_\_\_\_

**Please number the following outcome objectives in order of importance (1 being most important):**

- Knowledge of scoliosis     Improve torso appearance     Improve stamina
- Reduce pain     Increase quality of life     Improve mobility
- Improve posture control     Psychological well being     Reduce disability
- Better breathing     Reduce need for frequent clinic treatment as adult
- Reduce progression in adulthood

**Scoliosis can be considered a lifelong disease process. In order for conservative, non-surgical scoliosis treatments to work effectively, ongoing lifetime care must be undertaken by the patient. Otherwise, medical research demonstrates that scoliosis will get worse by 1-2 degrees per year for the remainder of the patient’s life if nothing is done to reverse the process.**

While Doctor(s) is waiting for payment for all of the fees, I agree to provide the office with information and forms regarding any source of potential payment, to assist in any way I can, and:

1. I hereby assign to Doctor(s) my rights to receive payments from negligent parties or from insurance companies responsible for my claim.
2. I hereby authorize the direct payment to Doctor(s) of any sum I now or hereafter owe you by my attorney out of proceeds of any settlement of my case and by any insurance company obligated to make payment to me or you based in whole or in part upon the charges made for your services.
3. You are authorized to release any information including the diagnosis and records of any such treatment to any insurance company, attorney or claims adjustor to process any claim for reimbursement of charges incurred.
4. I hereby assign and transfer to you the cause of action that exists in my favor, including the right to proceed via AAA Arbitration or Superior Court, against the insurance company or third party responsible for this claim to collect any unpaid bills. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.

*I also understand some of the procedures incorporated into my scoliosis treatment may be deemed experimental by some insurance for use in pediatric and adolescent cases because they are so new. All reasonable and necessary fees incurred by me at this clinic for treatment and/or rehabilitation equipment are my responsibility regardless whether my health insurance pays any portion of it.*

**METHOD OF PAYMENT**

Cash    Check    Credit/Debit

Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the office. I understand the above information and guarantee this form was completed correctly and to the best of my knowledge and I understand it is my responsibility to inform this office of any changes in my medical status.

Signature \_\_\_\_\_ Date \_\_\_\_\_





## SRS-22r Patient Questionnaire

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
                             First                            MI                            Last                            Mo          Day          Yr

Today's Date: \_\_\_\_\_ Age: \_\_\_\_\_  
                             Mo          Day          Yr                            Yrs          Mo

Medical Record #: \_\_\_\_\_

**INSTRUCTIONS:** We are carefully evaluating the condition of your back and it is **IMPORTANT THAT YOU ANSWER EACH OF THESE QUESTIONS YOURSELF.** Please **CIRCLE THE ONE BEST ANSWER TO EACH QUESTION.**

1. Which one of the following best describes the amount of pain you have experienced during the past 6 months?

- None
- Mild
- Moderate
- Moderate to severe
- Severe

2. Which one of the following best describes the amount of pain you have experienced over the last month?

- None
- Mild
- Moderate
- Moderate to severe
- Severe

3. During the past 6 months have you been a very nervous person?

- None of the time
- A little of the time
- Some of the time
- Most of the time
- All of the time

4.. If you had to spend the rest of your life with your back shape as it is right now, how would you feel about it?

- Very happy
- Somewhat happy
- Neither happy nor unhappy
- Somewhat unhappy
- Very unhappy

5. What is your current level of activity?

- Bedridden
- Primarily no activity
- Light labor and light sports
- Moderate labor and moderate sports
- Full activities without restriction

6. How do you look in clothes?

- Very good
- Good
- Fair
- Bad
- Very bad

7. In the past 6 months have you felt so down in the dumps that nothing could cheer you up?

- Very often
- Often
- Sometimes
- Rarely
- Never

8. Do you experience back pain when at rest?

- Very often
- Often
- Sometimes
- Rarely
- Never

9. What is your current level of work/school activity?

- 100% normal
- 75% normal
- 50% normal
- 25% normal
- 0% normal

**(CONTINUED ON NEXT PAGE) 3**

10. Which of the following best describes the appearance of your trunk; defined as the human body except for the head and extremities?

- Very good
- Good
- Fair
- Poor
- Very Poor

11. Which one of the following best describes your pain medication use for back pain?

- None
- Non-narcotics weekly or less (e.g., aspirin, Tylenol, Ibuprofen)
- Non-narcotics daily
- Narcotics weekly or less (e.g. Tylenol III, Lorcet, Percocet)
- Narcotics daily

12. Does your back limit your ability to do things around the house?

- Never
- Rarely
- Sometimes
- Often
- Very Often

13. Have you felt calm and peaceful during the past 6 months?

- All of the time
- Most of the time
- Some of the time
- A little of the time
- None of the time

14. Do you feel that your back condition affects your personal relationships?

- None
- Slightly
- Mildly
- Moderately
- Severely

15. Are you and/or your family experiencing financial difficulties because of your back?

- Severely
- Moderately
- Mildly
- Slightly
- None

16. In the past 6 months have you felt down hearted and blue?

- Never
- Rarely
- Sometimes
- Often
- Very often

17. In the last 3 months have you taken any days off of work, including household work, or school because of back pain?

- 0 days
- 1 day
- 2 days
- 3 days
- 4 or more days

18. Does your back condition limit your going out with friends/family?

- Never
- Rarely
- Sometimes
- Often
- Very often

19. Do you feel attractive with your current back condition?

- Yes, very
- Yes, somewhat
- Neither attractive nor unattractive
- No, not very much
- No, not at all

20. Have you been a happy person during the past 6 months?

- None of the time
- A little of the time
- Some of the time
- Most of the time
- All of the time

21. Are you satisfied with the results of your back management?

Very satisfied

Satisfied

Neither satisfied nor unsatisfied

Unsatisfied

Very unsatisfied

22. Would you have the same management again if you had the same condition?

Definitely yes

Probably yes

Not sure

Probably not

Definitely not

Thank you for completing this questionnaire. Please comment if you wish.

## Functional Medicine Laboratory Testing Informed Consent

The purpose of functional medicine laboratory testing in our office is to evaluate nutritional, biochemical, or physiological imbalance and to determine any need for medical referral. These lab tests in our office are not intended to diagnose disease. This office utilizes conventional lab tests as well as functional medicine assessment.

Functional medicine assessment is designed to assist our doctors and other healthcare providers in finding the underlying causes of your condition. Functional medicine has evolved through the efforts of scientists and clinicians from the fields of clinical nutrition, molecular biology, biochemistry, physiology, conventional medicine, and a wide array of scientific disciplines. Functional medicine evaluates the body as a whole, with special attention to the relationship of one body system to another and the nutrient imbalances and toxic overload that may adversely affect these relationships.

Your conventional medical physician may or may not agree with the necessity for—or our interpretation of—these tests. If you have any questions or concerns, please discuss them with our doctors.

I have read and understand the above:

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date