# 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

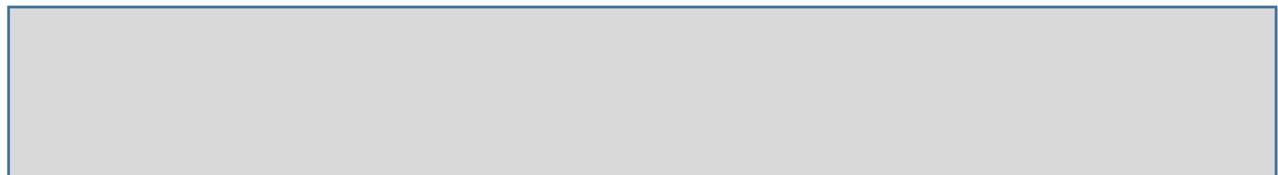
Are there any problems with balance, fine motor control, or dexterity? ❑ No ❑ Yes

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? ________________________________

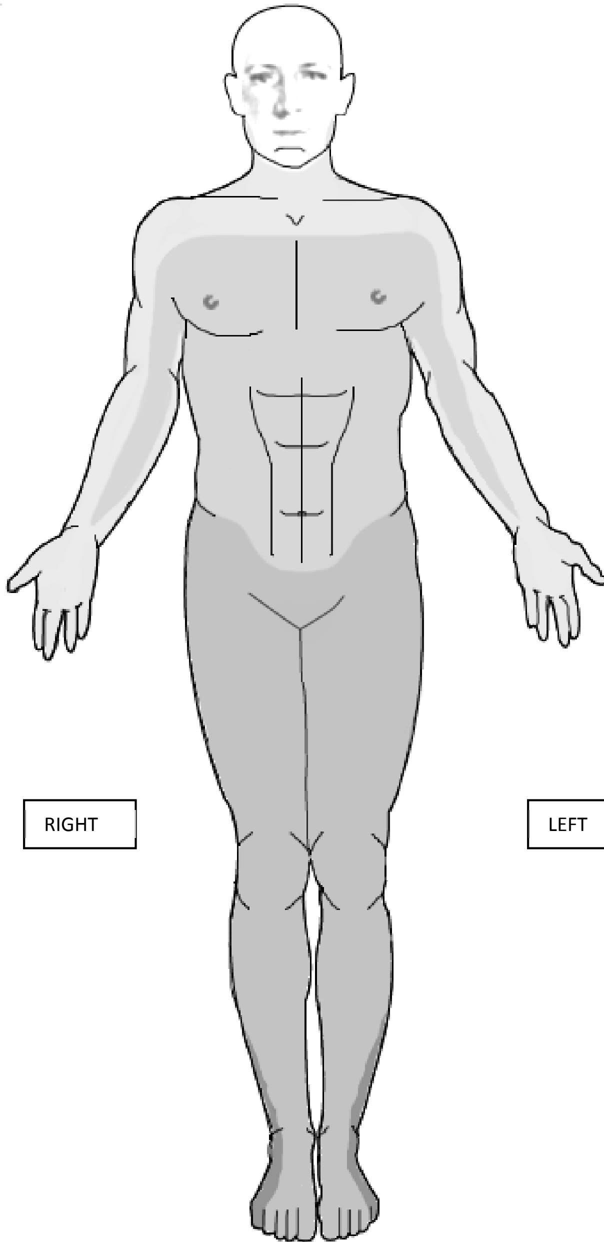
________________________________________________________________________________________

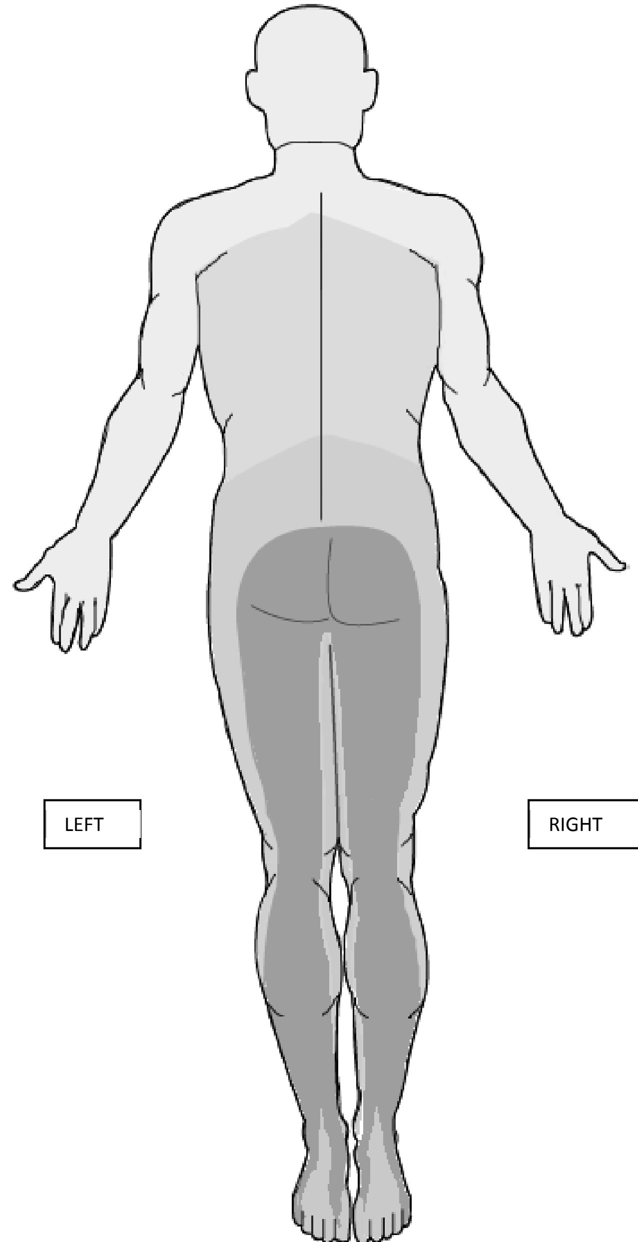
________________________________________________________________________________________

## 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* |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

**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: ______________________