

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

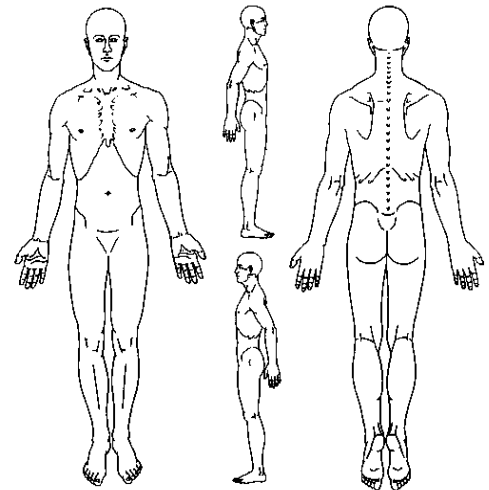
Have You Seen Other Doctors For Treatment? Yes No

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 _____

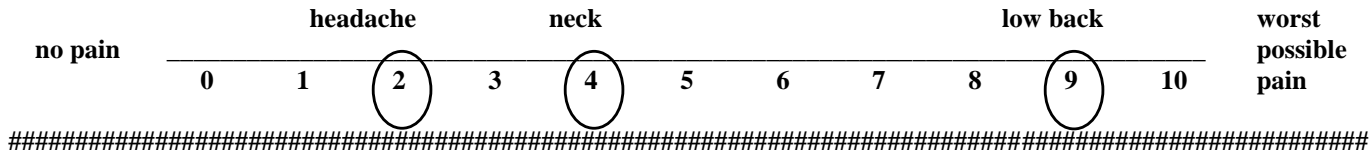


QUADRUPLE VISUAL ANALOGUE SCALE

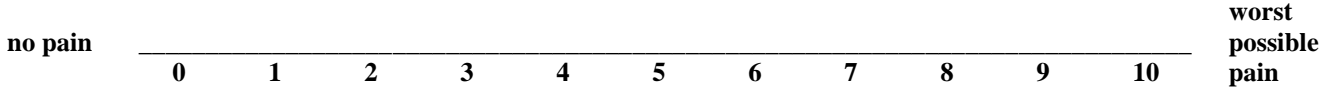
INSTRUCTIONS: Please circle the number that best describes the question being asked.

NOTE: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your average pain levels and pain at minimum / maximum using the last 3 months as your reference. If you have completed this form before, indicate you average pain level since the last time you completed this form.

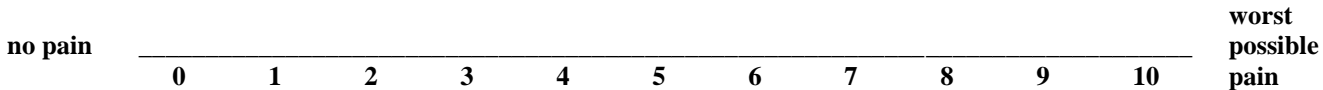
EXAMPLE:



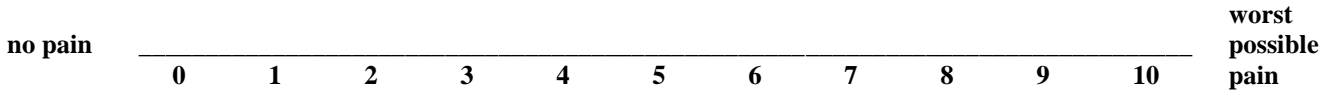
1. What is your pain RIGHT NOW?



2. What is your TYPICAL or AVERAGE pain?

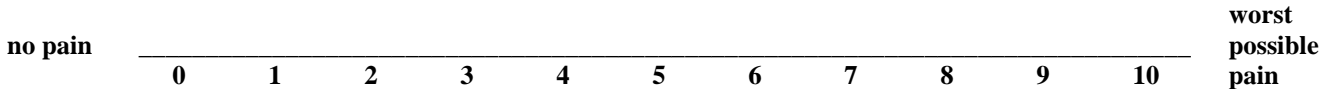


3. What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?



What percentage of your awake hours is your pain at its best? _____%

4. What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?



What percentage of your awake hours is your pain at its worst? _____%

NAME _____ AGE _____ DATE _____

SCORE _____

SCORE: #1 _____ + #2 _____ + #4 _____ = _____ / 3 x 10 = _____ (Low intensity = <50; High intensity = >50)

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