

**PALM BEACH ORTHOPAEDIC INSTITUTE, P.A.**  
**HISTORY FORM – NEW PATIENT PEDIATRIC SCOLIOSIS/SPINE**

Reason for Visit: \_\_\_\_\_ When did the problem start (date): \_\_\_\_\_

What were the events leading to its detection: \_\_\_\_\_

Precipitating Factors:  Auto accident  Fall  Illness  Injury  Sports: \_\_\_\_\_  None Known

**Has back pain been present?**

- No
- Yes

**If back pain, describe the pain/sensation:**

- Sharp
- Dull
- Throbbing
- Stabbing

**Location of back pain:**

- Cervical
- Thoracic
- Thoracolumbar
- Lumbar
- Lumbosacral
- Other: \_\_\_\_\_

**Severity: (1-10):**

0 1 2 3 4 5 6 7 8 9 10  
*mild moderate severe*

**How often are the symptoms/pain?**

- Never
- Occasionally
- Constantly

**Radiation:**

- No
- Yes, location: \_\_\_\_\_

**Night Pain:**

- No
- Yes

**Does this pain wake you from sleep:**

- No
- Occasionally
- Constantly

**Is the pain only activity related:**

- N/A
- No
- Yes, activities: \_\_\_\_\_

**Activity Limitations:**

- No
- Yes, examples: \_\_\_\_\_

**Is the problem getting worse:**

- No
- Yes, in what regard: \_\_\_\_\_

**Is there anything that helps to alleviate the pain?**

- Heat
- Ice
- Lying down
- Rest
- Sitting
- Standing

Explain: \_\_\_\_\_

**Has there been any:**

- Bruising
- Numbness
- Rashes
- Redness
- Swelling
- Tingling
- Weakness

Explain: \_\_\_\_\_

**THERAPY**

**Have you undergone any Physical Therapy?**

- No
- Yes
- Previously
- Currently being treated, frequency: \_\_\_\_\_

**Have you undergone any Occupational Therapy:**

- No
- Yes
- Previously
- Currently being treated, frequency: \_\_\_\_\_

**Current or past sports/physical activity participation:** \_\_\_\_\_

**When did you first start your period?**

- (year) \_\_\_\_\_ (age) \_\_\_\_\_
- N/A (male)

**Bladder or Bowel dysfunction:**

- No
- Yes

**Family History of Spinal Deformity:**

- No
- Yes, who: \_\_\_\_\_

**Additional Information:** \_\_\_\_\_

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**PAST ORTHOPAEDIC PROBLEMS**

Has your child had any:  Fractures: \_\_\_\_\_  Dislocations: \_\_\_\_\_  Surgeries: \_\_\_\_\_  
List body part: \_\_\_\_\_  
List treatment: \_\_\_\_\_

Soft bones/bone cysts or tumors:  No  Yes  
Neuromuscular Disorder:  No  Yes  
Benign or Malignant Cancers:  No  Yes  
Torn tendon/muscle:  No  Yes  
Inherited bone/joint disorder:  No  Yes  
Chronic infections:  No  Yes

**PAST MEDICAL HISTORY**

Has your child had any medical problems:  No  Yes: \_\_\_\_\_

Has your child had any previous surgeries:  No  Yes: \_\_\_\_\_

**Allergies\***

No known drug allergies  
 Food allergies: \_\_\_\_\_  
 Drug allergies: \_\_\_\_\_  
\_\_\_\_\_

**Medications\***

No daily medications  
 Daily medications: \_\_\_\_\_  
 Vitamins: \_\_\_\_\_  
 Herbal supplements: \_\_\_\_\_

**Any difficulty with anesthesia?**

No  
 Yes, explain: \_\_\_\_\_  
\_\_\_\_\_

**Any family history of bleeding disorders?**

No  
 Yes, who: \_\_\_\_\_  
\_\_\_\_\_

**Any exposure to hepatitis?**

No  
 Yes, explain: \_\_\_\_\_  
\_\_\_\_\_

Prior Surgeries and Hospitalizations or Serious Injuries (if not discussed above):

**FAMILY HISTORY**

	Age (if living)	Diseases	If deceased, Cause and Age of Death
Father:	_____	_____	_____
Mother:	_____	_____	_____
Brothers:	_____	_____	_____
Sisters:	_____	_____	_____

**PATIENT SOCIAL HISTORY**

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Grade: \_\_\_\_\_ Lives with: \_\_\_\_\_  
School problems/behavior problems: \_\_\_\_\_  
Family Physician: \_\_\_\_\_  
Other Doctors: \_\_\_\_\_

