

**2902 McFarland Road  
Suite 300  
Rockford IL 61107**

**Scoliosis/Kyphosis  
This Form is to be Printed**



**Phone: 815/316-2100  
Fax: 815/316-2099  
[rockfordspine.com](http://rockfordspine.com)**

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**Please bring this form with you to your appointment, do not drop it off beforehand**

Pediatric & Adolescent Scoliosis/Kyphosis Questionnaire

Only fill out this form if you are seeing the doctor for Scoliosis or Kyphosis. Please fill out this form completely and neatly. If you have any questions, please ask the nurse.

DATE \_\_\_\_\_ PATIENT NAME \_\_\_\_\_ Date of Birth \_\_\_\_\_

Developmental History:

Birth: Premature x \_\_\_\_\_ wks or Normal time

Problems at birth:

Approximate Height \_\_\_\_\_ Weight \_\_\_\_\_

Approximate growth in last 6 months \_\_\_\_\_

Height of mother \_\_\_\_\_ Height of father \_\_\_\_\_

Height of siblings \_\_\_\_\_

How was scoliosis/kyphosis discovered? \_\_\_\_\_

Previous treatment for scoliosis/kyphosis \_\_\_\_\_

Have menses/periods begun? **YES/NO** Approximate date begun \_\_\_\_\_

Are your menses/periods regular? **YES/NO**

Previous surgeons seen for treatment of scoliosis/kyphosis \_\_\_\_\_

