Patient History

(Please Print and Complete All Sections)

ALIGN THERAPY

Patient Name:_____ Age:_____

Today's Date:____ / ____ / ____ Last MD Visit:____ / ____ / ____ Next MD Visit: ____ / ____ / ____

Past Medical History: (Please mark if you have had any of the following)

___ High Blood Pressure ___Cancer ___ Back Injury ___ Diabetes

___ Heart Problems ___ Neck Injury ___ Osteoporosis ___ Lung Problems

___ Other Serious Injury ___ Arthritis ___ Unexplained Weight Loss ___ Any other medical Condition

Please explain those marked above:

_____

_____

Please list any current medications you are taking:

_____

_____

Current Condition:

Briefly describe the history of your back.

_____

_____

_____

Please fill out the following if known

Date of Diagnosis_____ Cobb Angle _____ Risser Score _____ Bracing Y / N

Family history of scoliosis:_____.

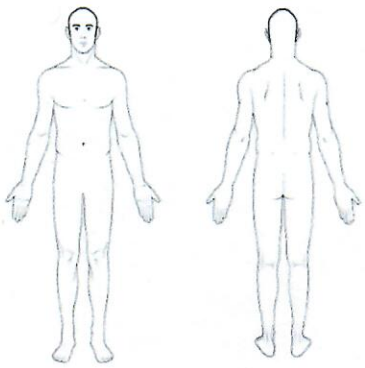
Other treatments tried:_____.

Please List any diagnostic tests and results (X-Ray, MRI, etc.) _____.

Have you had surgery for your back? YES / NO

Pain:

On the diagram, please mark areas of pain with an "X" and areas of numbness with an "O"



Rate the intensity of pain: (circle one) At its lowest: 0 1 2 3 4 5 6 7 8 9 10

Highest: 0 1 2 3 4 5 6 7 8 9 10

Right Now: 0 1 2 3 4 5 6 7 8 9 10

Describe your pain. Circle all that apply: Aching Shooting Numbness Soreness Tingling

Sharp Burning Throbbing Stabbing Dull Pressure

Other:_____.

What increases your pain: _____

What relieves your pain: _____

Function:

Are you working? YES NO List your job requirements/expectations:_____.

What activities are you NOT able to do now?

_____.

What goals do you hope to achieve by coming to therapy?

_____.

Signature: _____ Date: ____ /____ /____