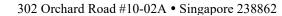


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PERSONAL HEALTH HISTORY

| Patient's Name | | Date of Birth | | Date | | | | | |
|--|--|--|----------------------------|---|--|--|--|--|--|
| The following form is to be completed prior to your consultation and emailed to the above contact details. Upon receiving the questionnaire, we will contact you via email to schedule your first consultation. Please complete the health history questionnaire. If you have any test results, etc. please feel free to attach copies along with any pertinent information not covered here. All information will be kept strictly confidential. Please check the degree of all conditions you currently have or have had. To be responsible for your case, we need your complete health history. | | | | | | | | | |
| O = Occa | sional | F = Frequent | C = Constant | | | | | | |
| O F C | O F C | | OFC | | | | | | |
| Muscle / Joint Arthritis Bursitis Foot trouble Hernia Low back pain Lumbago Neck pain, stiffness Pain between shoulders General Allergy Chills Convulsions Dizziness Fainting Fatigue Fever Headache Loss of sleep Loss of weight Nervousness, depression Neuralgia Numbness Sweats Tremors | □ Dry □ Hiv □ Itch □ Ski □ □ □ Val Pain or num □ Arr □ Elb □ Ha □ Hip □ Leç □ Fai □ Poi □ Sci □ Spi | nise easily ness es or allergy ning n eruptions (rash) ricose veins bness in bulders ns ows nd is gs ees et nful tailbone prosture | Respiratory CC CC CS SI W | Hardening of arteries High blood pressure Low blood pressure Pain over heart Poor circulation Rapid heartbeat Slow heartbeat Swelling of ankles | | | | | |
| Describe your problem if scoliosis state the degree and type of curve: How long have you had this condition? Is it getting worse? Yes No Does it bother your (check appropriate box): □ Work □ Sleep □ Other (please specify) What seemed to be the initial cause? | | | | | | | | | |
| Are you under the care of a physician? Yes No If yes, for what reason? | | | | | | | | | |
| Have you been hospitalized in the last 5 years? Yes No If yes, for major surgery? Yes No for serious injury? Yes No | | | | | | | | | |
| Have you had any mental or emotional disorders? ☐ Yes ☐ No If yes, when? | | | | | | | | | |
| Indicate the drugs do you now take? ☐ Birth control pills ☐ Tranquilizers ☐ Pain Killers ☐ Other (specify) Do you wear: ☐ book lifte? ☐ sole lifte? ☐ inner soles? ☐ area supports? ☐ pagetive books? ☐ pletform shees? | | | | | | | | | |
| • | Do you wear: ☐ heel lifts? ☐ sole lifts? ☐ inner soles? ☐ area supports? ☐ negative heels? ☐ platform shoes? | | | | | | | | |
| How is most of your day spent? ☐ standing ☐ sitting ☐ walking ☐ other (specify) | | | | | | | | | |



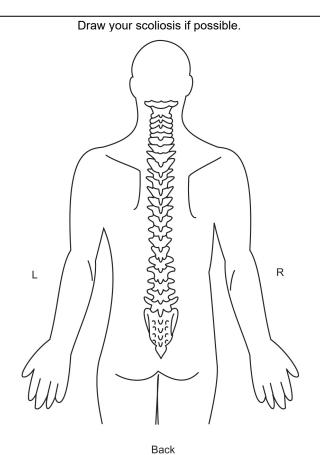


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| Have you ever: | | Yes | No | If yes, briefly explain. | | | |
|--|--|--------------------|---------|--|--|--|--|
| - had a broken bone? | | | | | | | |
| - been hospitalized? | | | | | | | |
| - had strains or sprains? | | | | | | | |
| - used a cane, crutch or of | | | | | | | |
| - been struck unconscious | | | | | | | |
| - been hospitalized for oth | er than surgery? | | | | | | |
| Do you: - take minerals, herbs or v | ritamins? | | | | | | |
| - think you need minerals, | | | | | | | |
| - have any drug allergy? | | | | | | | |
| When did you last have: | | Never | - | 0-6 months. 6 -18 months. Longer | | | |
| spinal x-ray?spinal examination?physical examination? | | Nevel | | 0-0 months. 0 - 10 months. Longer | | | |
| | h conditions you have | o hoon | trooted | for an augment you have had in the last ten years | | | |
| Please list any other health conditions you have been treated for, or surgery you have had in the last ten years. | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| FAMILY HEALTH HISTO us a better understanding | RY : Information about of your total health p | ut your icture. | immedia | ate family members, brothers, sisters, parents, and grandparents will give | | | |
| RELATIONSHIP | PRESENT AND PA | AST HE | ALTH P | PROBLEMS | | | |
| | | | | | | | |
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| PATIENTS HEALTH HISTORY: Information about your history living with scoliosis. Include information about when it was first diagnosed, how it has progress, symptoms related or unrelated to scoliosis, types and dates of treatment you have and anything else not discussed above which you would like to inform Dr. Kevin Lau. | | | | | | | |
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Please mark your areas of pain on the figures below.

