Dr. Jane Leavell, DC
4045 Wadsworth Blvd, Suite 30
Wheat Ridge, CO 80033
(303) 452-7300 frontdesk@RhinoSC.com

Health History

Patient Name: ____ **Date:** ______________________

When was your scoliosis first diagnosed?____

What was the Cobb angle?_______________ Who diagnosed it?___________________________________

How was your scoliosis treated?____

Please list the names of the physicians and / or clinics who treated you:______________________________

____

Did the Cobb angle change after treatment?_________ If yes, what did it change to?__________________

When was your last x-ray and what was the Cobb angle?____

What are you currently doing to treat your scoliosis?____

What is your primary motivation in wanting to correct your scoliosis?_______________________________

____

List any family members with scoliosis and how they were treated:_________________________________

____

Do you have any friends or family members who are unaware of your scoliosis?__________ If so, would it matter to you if they found out?____

Height:_________ Weight:_________ Have you gained or lost weight within the last year? Yes No

If yes, how much and why:____

Previous Chiropractic Care: ☐ This is my first chiropractic visit. OR

☐ Doctor's Name / Length of Care / Approximate Date of Last Visit:________________________________

____

Do you use: ☐ Brace (if so, type) ___________________________________ ☐ Supports ☐ Wraps

☐ Heel Lifts ☐ Prosthetics ☐ Orthotics Describe length of use and purpose:___________________

____

Allergies: Please include environmental, food, and medication allergies:_______________________________

____

____

Patient Name: ____

Sleep: Usual bed time:___________ Usual wake-up time:___________ Usual hours of sleep:___________

I sleep mostly on my: ☐ Back ☐ Stomach ☐ Sides

Exercise: ☐ None ☐ Light ☐ Moderate ☐ Strenuous Describe: ___________________________

Water: ☐ 8 glasses every day ☐ Some water daily ☐ Really don't like water ☐ Never drink it

Please list the hobbies and activities you enjoy on a daily basis: ___________________________________

____

How much time do you spend each day: Watching television?_________________________

Playing video games?_________________________ Exercising?_________________________

Do you have any pets?_______ If so, what kinds?____

How many cans of soda do you drink a day?________________ Regular or diet?___________________

How often do you eat fruits and vegetables?____

What are your favorite foods?____

____

Illnesses / Surgeries / Hospitalizations: Please check if you have had:

☐ Surgery ☐ Hospitalization ☐ Broken Bones ☐ Head Trauma ☐ Bad Fall ☐ Sports Injury

☐ Car accident (even if minor) ☐ Birth trauma or complications, such as Caesarean delivery

Please list year and explain details:____

____

____

Have you ever been diagnosed with any other diseases or conditions?___________ If so, please list year and details:____

Do you take any prescription or non-prescription medications on a regular basis?__________ If so, please list dosage and frequency:____

Are you currently talking any vitamins or nutritional supplements?_______ If so, which ones?____________

____

Please check if anyone in your family has been diagnosed with: ☐ Cancer ☐ Diabetes ☐ Arthritis

☐ Heart Disease ☐ Other:____

____ ____________________

Patient / Parent / Guardian Signature Date