

PHYSICIAN'S SCOLIOSIS REPORT 19 - 19



Name _____ Age _____ Physician _____

HISTORY

Prior Awareness: No _____ Yes _____ How Long _____

Symptoms/Complaints: _____

Family History of Scoliosis: No _____ Yes _____

If "yes", indicate relationship

Remarks: _____

Under care prior to screening: No _____ Yes _____

FINDINGS

- X-Ray Not Indicated _____ X-Ray Results: 1. Negative _____
2. Scoliosis _____
- a. Mild (0-10) _____
- b. Moderate (11-30) _____
- c. Severe (30 +) _____
3. Kyphosis/Lordosis _____
4. Other _____

RECOMMENDATIONS

1. Discharged: _____
2. Rescreen (when?): _____
3. Repeat AP Standing X-Ray: _____
4. Other: _____
5. Refer for Orthopedic Evaluation: _____

Physician's Signature _____

Date _____