



Intensive Intake (Scoliosis Consult Form)

Name: _____ Birthdate: _____ Age: _____ M F

Address: _____ City: _____ State: _____ Zip: _____

E-mail: _____ Home#: _____ Cell#: _____

Height: _____ Weight: _____ If Female, Date Started of Menses: _____

Current Activities: _____

Guardian's Name: _____ Relationship: _____ Height of Patient's; Mother: _____ Father: _____

How did you hear about Dr. Nick Weddle? _____

Current Condition: _____ Date Diagnosis: _____ By Who: _____

Degree of curvature when diagnosed: _____ What was the recommendations? _____

When diagnosed, what treatment did you do? _____

What were the results? _____

Who is your current Doctor and what do they recommend? _____

Date of your most current x-rays? _____ Degree measured at that time? _____

Any other Doctor that you have seen for this condition and what did they recommend?

Any Family Hx of Condition: _____ If yes; describe: _____

Any other health concerns? _____

Any surgeries: _____ If yes; describe: _____

Any injuries, trauma or broken bones: _____ If yes, describe: _____

Additional information you would like Dr. Nick to Know:

Doctor Notes:

I understand that this is a consultation and is NOT meant to replace a complete exam or evaluation. The intent of this consultation is not to diagnose or treat any condition, but merely to review your case and discuss the available options, answer questions, and discuss the current treatment models. I understand the doctor doesn't have all data necessary to make a complete diagnosis or prognosis regarding treatment, exams, x-rays, and any other testing.

Patient/Guardian Signature _____ Date: _____