CLEAR
SCOLIOSIS CENTER

Intensive Intake (Scoliosis Consult Form)

Please initial: I have listened to the Consultation Video on ScoliosisKC website and have written down my questions _____

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:_____

_____ (please initial here and sign below) -- I would like to have an X-ray during my consultation today. Please see the front desk for cost on the X-ray.

REGARDING X-RAYS/IMAGING STUDIES

FEMALES ONLY→ please read carefully and check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our receptionist for further explanation.

☐ The first day of my last menstrual cycle was on _____/_____/_____ Date

☐ I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant.

By my signature below I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

MALES/FEMALES: By my signature below, I understand and give consent to be x-rayed if the doctor deems necessary.

_____ ____/____/____ _____

Patient or Authorized Person's Signature Date Witness Initials