



**Indiana Scoliosis Specialists
14074 Trade Center Drive
Fishers, Indiana 46038
317-770-5775**

BRACING AGREEMENT

I understand that the Spinecor Scoliosis Bracing Device is an effective way of changing scoliosis curves in adolescent children and results may vary depending on curve type, growth, age, and compliance. I understand that bracing with the SpineCor Bracing Device does not guarantee curve correction and that 10% of all scoliosis patients will require surgery regardless of what measures are taken to reduce the curves. I am also aware that the SpineCor Bracing Device does not offer correction in adults with scoliosis and that the Spinecor Bracing Device is for structural support and possibly slowing the advancement in adult scoliosis.

I have been informed (explained) of the cost of this brace, and any other fees that may be needed to complete the bracing visit in advance. I have also been informed of the amount of follow up visits and the cost for each visit. I am fully aware that Scoliosis Specialists does not accept insurance.

I understand that payment is required at the times of service and no refunds will be issued once the patient leaves our office with the Spinecor Scoliosis Bracing Device.

Print Name: _____

Signature: _____

Date _____



Indiana Scoliosis Specialists
CONFIDENTIAL PATIENT INFORMATION

Patients Name (First) _____ (M) _____ (Last) _____

Address: _____
Street

City _____ State _____ Zip Code _____

Home Phone: _____ - _____ - _____ Work Phone: _____ - _____ - _____

D.O.B. ____/____/____ S.S. #: _____ - _____ - _____

Sex: M _____ F _____ Patient Status: _____ Single _____ Married _____ Other _____

Employed _____ Student _____

Employer/ School: _____ Phone: _____ - _____ - _____

Address: _____
Street City State Zip Code

Referring Physician: _____

Phone _____ - _____ - _____

Patient/ Parent Guardian Signature

Date



Indiana Scoliosis Specialists Confidential Patient Medical History

Date: _____ Date of last physical: _____

Name: _____ Date of Birth: _____

Present Complaints:

Are you here for the evaluation/ treatment of scoliosis? Yes _____ No _____

Do you have any complaints associated with or in addition to scoliosis: Yes _____ No _____

Have you been diagnosed with scoliosis? Yes _____ No _____

Please describe any **CURRENT** complaints and rate their pain from 1-10.

(1 being least serious/ painful and 10 being most serious/ painful)

1. _____ 1-2-3-4-5-6-7-8-9-10

2. _____ 1-2-3-4-5-6-7-8-9-10

3. _____ 1-2-3-4-5-6-7-8-9-10

4. _____ 1-2-3-4-5-6-7-8-9-10

When and how did your complaint(s) occur? _____

Symptoms appeared to develop from: (check each one that applies to your symptoms)

SCOLIOSIS _____ JOB RELATED INJURY _____ AUTO ACCIDENT _____ ACCIDENT _____ BIRTH _____

ILLNESS _____ UNKNOWN CAUSE _____ GRADUAL ONSET _____ date occurred: _____

Symptoms have persisted for: Hours _____ Day(s) _____ Week(s) _____ Month(s) _____ Yr(s) _____

Symptoms are typically worse in the A.M. _____ Afternoon _____ P.M. _____

Symptoms and/ or complaints: Come and Go _____ Are Constant _____

Have you ever had this before: No _____ Yes (when?) _____

If you were to guess, what do you think caused the problem/ pain? _____

Give name and location of doctors previously seen for this/ these condition(s): _____

Please check the following activities that **AGGRAVATE** your condition:

BENDING___ REACHING___ COUGHING___ SITTING___ TURNING HEAD___ LIFTING___
SNEEZING___ WALKING___ LYING DOWN___ STANDING___ STRAINING AT STOOL___

Please check the following activities that relieve your condition:

BENDING___ REACHING___ COUGHING___ SITTING___ TURNING HEAD___ LIFTING___
SNEEZING___ WALKING___ LYING DOWN___ STANDING___

Please check any **ADDITIONAL SYMPTOMS** you may be experiencing:

Blurred Vision___

Buzzing in Ears___

Cold Feet___

Cold Hands___

Cold Sweats___

Confusion___

Constipation___

Depression___

Diarrhea___

Dizziness___

Face Flushed___

Fainting___

Fever___

Head seems to heavy___

Headaches___

Insomnia___

Light bothers eyes___

Loss of Balance___

Loss of Smell___

Loss of Taste___

Low Resistance to Colds___

Muscle Jerking___

Numbness in Fingers/ Arms___

Numbness in toes/legs___

Pins and Needles in Arms___

Ringing in Ears___

Shortness of breath___

Stiff Neck___

Stomach Upset___

Coordination Difficulties___

CURRENT MEDICAL HISTORY

Have you ever been treated for scoliosis? No___ Yes (when?)_____ Name and location of
doctors previously seen for scoliosis treatment_____

Have you worn or do you wear a scoliosis brace? No___ Yes (What type?)_____

Have you been treated for any other health condition in the last year? No___ Yes (describe) _____

Are you allergic to any medications? No___ Yes (what kind?)_____

Are you taking any medications? No___ Yes (what kind?)_____

Are you taking nutritional/ vitamin supplements? No___ Yes (what kind?)_____

Are you pregnant? No___ Yes (date of last menstrual period)

Have you ever had a metal implant? No___ Yes (describe procedure)_____

FAMILY MEDICAL HISTORY

Are you aware of anyone in your immediate family that has/ had scoliosis? (check any that are applicable)

Mother _____ Father _____ Sister _____ Brother _____

Are you aware of anyone in your distant family that has/ had scoliosis? No _____ Yes _____

Who? _____

Please indicate which **PAST** conditions have been experienced prior to present complaint by checking appropriate person. (S= Self M= Mother F=Father)

<u>S</u>	<u>M</u>	<u>F</u>	
			<u>Musculoskeletal System</u>
___	___	___	Head Pain/ Problems
___	___	___	Neck Pain/ Problems
___	___	___	Shoulder Pain/Problems
___	___	___	Arm Pain/ Problems
___	___	___	Hand Pain Problems
___	___	___	Mid back Pain Problems
___	___	___	Chest Pain/ Problems
___	___	___	Stomach Pain/ Problems
___	___	___	Low back Pain/ Problems
___	___	___	Hip Pain/ Problems
___	___	___	Leg Pain/ Problems
___	___	___	Foot Pain/ Problems
___	___	___	Jaw Pain/ Problems

<u>S</u>	<u>M</u>	<u>F</u>	
			<u>Genito-Urinary System</u>
___	___	___	Bladder Trouble
___	___	___	Painful/ Excessive Urination
___	___	___	Discolored Urine
___	___	___	Bed wetting
			<u>Ear, Eyes, Nose, & Throat</u>
___	___	___	Sinus Problems
___	___	___	Vision Problems
___	___	___	Dental Problems
___	___	___	Sore Throat
___	___	___	Ear Aches
___	___	___	Ringling in Ears
___	___	___	Stuffed Nose

<u>S</u>	<u>M</u>	<u>F</u>	
			<u>Gastrointestinal System</u>
___	___	___	Poor/ Excessive Appetite
___	___	___	Excessive Thirst
___	___	___	Frequent Nausea
___	___	___	Vomiting
___	___	___	Diarrhea
___	___	___	Constipation
___	___	___	Hemorrhoids
___	___	___	Liver Problems
___	___	___	Gall Bladder Problems
___	___	___	Weight Trouble
___	___	___	Abdominal Cramps
___	___	___	Gas/ Bloating after meals
___	___	___	Heartburn
___	___	___	Black/ Bloody Stools
___	___	___	Colitis

<u>S</u>	<u>M</u>	<u>F</u>	
			<u>Male/ Female</u>
___	___	___	Menstrual Irregularity
___	___	___	Menstrual Cramping
___	___	___	Vaginal Pain/ Infections
___	___	___	Breast Pain/ Lumps
___	___	___	Prostate/ Sexual Dysfunction

<u>S</u>	<u>M</u>	<u>F</u>	
			<u>Cardiovascular/ Respiratory</u>
___	___	___	Chest Pain
___	___	___	Short Breath
___	___	___	Blood Pressure Problems
___	___	___	Irregular Heartbeat
___	___	___	Heart Problems
___	___	___	Lung Problems/ Congestion
___	___	___	Varicose Veins
___	___	___	Ankle Swelling
___	___	___	Stroke

<u>S</u>	<u>M</u>	<u>F</u>	
			<u>Nervous System</u>
___	___	___	Excessive Thirst
___	___	___	Frequent Nausea
___	___	___	Vomiting
___	___	___	Diarrhea
___	___	___	Constipation
___	___	___	Hemorrhoids
___	___	___	Liver Problems
___	___	___	Gall Bladder Problems
___	___	___	Weight Trouble

<u>S</u>	<u>M</u>	<u>F</u>	
			<u>Diseases</u>
___	___	___	Pneumonia
___	___	___	Rheumatic Fever
___	___	___	Polio
___	___	___	Tuberculosis
___	___	___	Whooping Cough
___	___	___	Mumps
___	___	___	Small Pox
___	___	___	Measles
___	___	___	Chicken Pox
___	___	___	Diabetes
___	___	___	Cancer
___	___	___	Influenza
___	___	___	Pleurisy
___	___	___	Arthritis

<u>S</u>	<u>M</u>	<u>F</u>	
			<u>Nervous System</u>
___	___	___	Fatigue
___	___	___	Allergies
___	___	___	Loss of Sleep
___	___	___	Fever

___ ___ Tension Headaches
___ ___ Migraine Headaches
___ ___ Sinus Headaches

___ ___ Epilepsy
___ ___ Mental Disorder
___ ___ Anemia
___ ___ Hepatitis
___ ___ Heart Disease
___ ___ Thyroid
___ ___ Lumbago
___ ___ Eczema

SURGICAL HISTORY

Have you ever had surgery to correct scoliosis? No ___ Yes (describe procedure) _____

Describe any other surgical procedures you have had.

1. _____ Date: _____

2. _____ Date: _____

3. _____ Date: _____

ACCIDENT HISTORY

___ JOB ___ AUTO ___ OTHER 1. _____ Date: _____

___ JOB ___ AUTO ___ OTHER 2. _____ Date: _____

___ JOB ___ AUTO ___ OTHER 3. _____ Date: _____

SOCIAL HISTORY

<u>HABIT</u>	<u>Heavy</u>	<u>Moderate</u>	<u>Light</u>	<u>None</u>
Alcohol	_____	_____	_____	_____
Coffee	_____	_____	_____	_____
Tobacco	_____	_____	_____	_____
Drugs	_____	_____	_____	_____
Exercise	_____	_____	_____	_____

Patient Signature _____ Date _____

Guardian Signature _____ Date _____



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SPINECOR BRACE PATIENT QUESTIONARE

We ask you to please take a moment to answer the following questions as best you ca. We respect your honesty and suggestions. This will be very helpful to us to better serve you and other new bracing patients.
Thank you.

Patient Name _____ **Date** _____

How long have you known about the scoliosis?

How did you discover you had scoliosis?

How did you hear about Scoliosis Specialists? _____

Have you worn any other brace or had any other treatment? If yes, what kind? _____

Please choose: ___ Initial bracing visit ___ Follow up ___ Consultation ___ X-Rays

How would you rate your initial consultation?

___ Poor ___ Average ___ Good ___ Excellent

Was all information pertaining to your brace visit provided during the initial consult?

___ No info provided ___ Some info provided ___ All info was provided

During the initial consult, was the cost of the brace discussed and explained to you?

___ Yes ___ No

Were all your questions answered during your consult?

___ None ___ Some ___ All

Did a scoliosis specialist doctor/ or receptionist greet you upon your arrival today?

___ Yes ___ No

Was the office staff polite and courteous/ helpful for your office visit today?

___ Yes ___ No (explain) _____

Did you have your initial x-rays taken at our office?

Yes No, previously taken at another facility Disc provided

Were your X-rays reviewed by a scoliosis specialist and explained in detail to you before anything took place?

Yes fully explained No (explain) _____

Do you feel that the doctor(s) performed a through clinical exam?

Yes No (explain) _____

Did the doctor(s) inform you or provide info pertaining to the exam? Shoulder tilt/ Rotation, Posture, etc...

Yes, very descriptive Somewhat No info provided

Did the doctor measure you to custom fit your brace?

Yes No

Did your pelvic shorts or pelvic base fit comfortably?

Yes, fit very well; no problems Average; brace a little uncomfortable No, too tight

How did you feel with the brace on after the doctor(s) made all the adjustments?

Very comfortable Comfortable Somewhat comfortable Not Comfortable

Did the doctor(s) ask you to move around in the brace? Sit, stand, bend, flex, etc....

Yes No

Was an X-ray taken with you in the brace?

Yes No

Was the in brace X-ray explained and reviewed?

Yes No

Were you given specific exercises to perform and were they demonstrated for you?

Yes No

How would you rate the doctor(s) overall competency of the brace fitting visit?

Very competent Average Not competent at all

Were all of your questions regarding your brace and the visit answered today?

Yes, all Some, but not all None

How would you rate the doctors overall knowledge of scoliosis?

Poor Average Good Excellent

How would you rate your overall experience today?

Poor Average Good Excellent

Any additional comments:

Completed by: (your name) _____

Signature: _____