

SCOLIOSIS SCREENING REPORT

School Year: _____

Name _____ Birth Date _____ Age _____ Sex M__ F__

Parents _____ Address _____

School _____ Grade _____ Family Physician _____

HISTORY

Prior Awareness: No__ Yes __ How Long _____

Symptoms, Complaints _____

Family history of Scoliosis No __ Yes __ (state relationship to student)

Remarks _____

	Under Care	Other Reason X-Ray
X-Ray Refused _____	Prior to Screening _____	Not Taken _____

SCREENING X-Ray Report

X-Ray Taken at _____ Read by _____

X-ray results: 1. Negative _____

2. Scoliosis _____	<u>Degree of Curve:</u>	<u>Type of Curve:</u>
	1. Less than 10° _____	1. Thoracic _____
	2. 10° to 20° _____	2. Double Major _____
	3. 20° to 40° _____	3. Thoracolumbar _____
	4. 40° to 55° _____	4. Lumbar _____
	5. More than 55° _____	5. Other _____
3. Kyphosis/Lordosis _____		
4. Other _____		

RECOMMENDATIONS

1. Discharge _____	2. Rescreen next year _____
Repeat AP Standing X-Ray:	3. 6 months _____ 4. 12 months _____
5. Other _____	6. Refer for Orthopedic Evaluation _____
7. Other _____	

Date

Physician Signature