THE LUSKIN
Orthopaedic
Institute for Children
IN ALLIANCE WITH UCLA Health

Expert Orthopaedic Care For All Children Since 1911
403 West Adams Boulevard, Los Angeles, CA 90007-2664

Scoliosis Questionnaire

Patient Name: _____

Please complete all questions to help us determine if your patient may be evaluated in our facility .

Age of Patient: _____

Sex of Patient:: ☐ Female ☐ Male

Sex of patient: ☐ Premenarchal ☐ Postmenarchal

Does patient have scoliosis X-rays: ☐ Yes ☐ No

What is the degree of the curve in Cobb angle? _____

Does the patient have back pain? ☐ Yes ☐ No

If yes, how long with the back pain? _____

Fax # 213-358-2746

Please fill out and fax back with referral form!

Thank you!

** Include X-ray report!