About You...

Name: _____ Date_____

Address:_____

_____

Phone:_____ Email:_____

Date of Birth: _____ Emergency Contact: _____

(mm/dd/yyyy) (Name / Phone #)

1. Has a medical professional diagnosed your spine with one of the following: *Circle One*

Hyper-kyphosis Hyper-lordosis Scoliosis

2. When was this condition first diagnosed?_____

3. Who diagnosed this condition?_____

4. Is your diagnosis a result of some other condition? (e.g.neurological, muscular, bone)

_____

_____

5. Do you have X-rays or MRI's? Yes / No *If yes, please bring them to our first meeting.*

6. Have you been diagnosed with other spine concerns such as osteoporosis, disc bulges or herniation, facet joint syndrome, stenosis, degenerative disc disease or any other concern?

Yes / No: If yes, please list which conditions:

_____

_____

_____

_____

Additional Information:

_____

_____

1. Do you know the degree of your curve or the Cobb angle? *Yes / No*

Degree:_____ Applies to Thoracic (mid-back) or Lumbar Spine (low back). *Circle One.*

Degree:_____ Applies to Thoracic (mid-back) or Lumbar Spine (low back). *Circle One.*

2. Has the degree changed since you were first diagnosed? *Yes / No.*

If yes, please elaborate: _____

3. Have you ever worn a scoliosis brace? Yes / No

If yes, Please Answer a-c:

a) How long did you wear the brace?_____

b) What age were you when you wore the brace?_____

c) What kind of brace? Or please describe the brace:_____

4. Have you ever had difficulty breathing? Yes / No

*If yes, do you know why?*_____

5. Do you have IBS (irritable bowel syndrome), acid reflux problems, digestive problems (including constipation and diarrhea) in general? Yes / No

If yes, please explain:_____

5. Do you have high blood pressure? Yes / No

6. Have you ever had surgery for scoliosis? Yes / No

*If yes, When?*_____ *What was performed?*_____

7. Have you ever had any other major surgery? Yes/No

*If yes, what was performed?*_____

8. Do you intend to have surgery for scoliosis?_____

9. Have you ever done an exercise program or physical therapy for your scoliosis? Yes / No

*If yes, when was performed?*_____

10. When you performed the exercise or physical therapy what result were you hoping for?

_____

11. Did you achieve the result you were hoping for? Yes / No

12. For both yes and no answers, what is your opinion on why the result was or was not achieved? Please use the back of this page if you need more space.

_____

_____

_____

13. Do you ever experience pain or discomfort related to the scoliosis or neurological condition? Yes / No

a. If yes, on a scale of 1-10 (no pain to excruciating pain) how would you describe the discomfort?

_____

b. If yes, when are the symptoms worse?

Morning Afternoon Evening Sleeping

c. If yes, please place hash marks (//////////) on the models on the next page to indicate locations of discomfort.

15. What relieves the symptoms?

_____

16. What makes the symptoms worse?

_____

17. Do you take medication for pain? Yes/No

a. If yes, what medication and how frequently._____

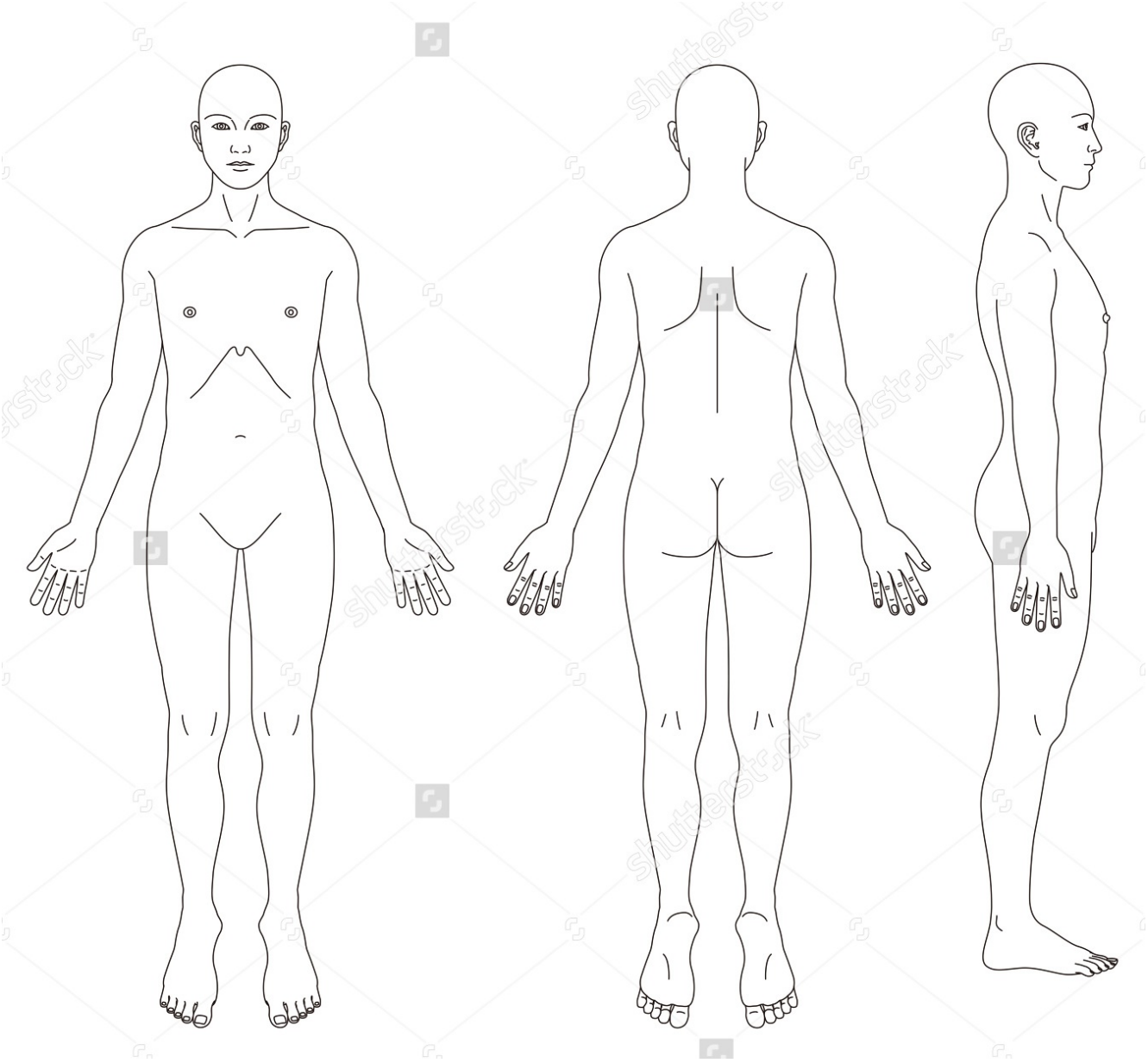
_____

18. If you have no scoliosis-related discomfort, what are you hoping to achieve from a program of exercise for scoliosis?

_____

_____

Mark the models below with /////// to indicate areas of concern or pain.



Are You Ready to Change?

Physical Activity Readiness to Change Score

Instructions: After carefully reading each statement below, please check the column that corresponds to your answer.

Definitions:

Physical Activity or Exercise: Includes such activities as walking briskly, jogging, bicycling, swimming or any other activity where the exertion is at least as intense as these activities. In terms of this program, we are adding your Scolio-Pilates® home exercise program to this definition.

Regular Physical Activity: Must add up to a total of 30 minutes or more per day and be done at least 5 days per week. For example, you could take one 30-minute walk or take three 10-minutes walks for a daily total of 30 minutes. Regular physical activity includes doing your Scolio-Pilates® home exercise program 5 days/week.

	Yes	No
1. I am currently physically active. [If yes, Skip to question 3]		
2. I intend to become more physically active in the next 6 months.		
3. I currently engage in regular physical activity.		
4. I have been regularly physically active for the last 6 months		

Sources: Marcus BH, 1992; Marcus and Forsyth, 1992

Confidence Score

Instructions: After carefully reading each statement below, mark how confident you are that you could be physically active, and able to do your ScolioPilates home exercise program, in each of the following situations.

Scale

1: Not at all Confident | 2: Slight Confident | 3: Moderately Confident | 4: Very Confident | 5: Extremely Confident

	1	2	3	4	5
1. When you are tired.					
2. When you are in a bad mood.					
3. When you feel you don't have time.					
4. When you are on vacation.					
5. When the weather is bad: Rain, snow, fog, cold, hot					

Are You Ready? Continued...

Pros vs. Cons and Decisional Balance Score

Instructions: After carefully reading each statement below, please rate how important each statement was in your decision of whether or not to become more physically active, including your Scolio-Pilates® home exercise program. In each case, think about how you feel right now, not how you have felt in the past or would like to feel.

Scale

1: Not at all Confident	2: Slight Confident	3: Moderately Confident	4: Very Confident	5: Extremely Confident

	1	2	3	4	5
1. I would have more energy for my family and friends if I were regularly physically active					
2. Regular physical activity would help me relieve tension.					
3. I think I would be too tired to do my daily work after being physically active and doing my Scolio-Pilates® Home Exercise Program.*					
4. I would like to do my home exercise program regularly to see if that will change my scoliosis-related symptoms.*					
5. I would sleep more soundly if I were regularly physically active.					
6. I would feel good about myself if I kept my commitment to performing my Scolio-Pilates® Home Exercise Program.					
7. I would find it difficult to enjoy and that would affect my desire to perform Scolio-Pilates® Home Exercise Program.*					
8. I look forward to the challenge of regular physical activity that might alleviate my symptoms and allow me to do the things I love.*					
9. It would be easier for me to do routine physical tasks if I were regularly physical active and performing my Scolio-Pilates Home Program.*					
10. I would feel less stressed if I was regularly physically active.					
11. I feel uncomfortable when I am physically active because I get out of breath and my heart beats very fast.					
12. I would feel more comfortable with my body if I were regularly physically active and performing my Scolio-Pilates® Home Program.*					
13. Regular physical activity would take too much time.					
14. Regular physical activity would help me have a more positive outlook					

on life.					
15. I would have less time for my family and friends if I were regularly physical active and performing my Scolio-Pilates® Home Exercise Program.					
16. At the end of the day, I am too exhausted to be physically active.					

*Sources: Marcus BH, 1992; Marcus and Forsyth, 1992 *edited for SP*

Release to use Photos taken during Assessments.

The assessment includes taking several photos: front, back and side-views. Part of the Mission of Authorized Scolio-Pilates® Experts is to share our findings. The goal of sharing our findings is to gain acceptance for exercise being used as a viable management tool for scoliosis in addition to, not at the exclusion of, observation, bracing and surgery. Sharing these photos will assist our profession as well as those seeking help for their own scoliosis symptoms.

I, _____(Print full name), hereby give permission to the Association of Authorized Scolio-Pilates® Experts to use my photographic likeness for professional reasons including sharing information with other Scolio-Pilates® Instructors as well in Professional venues.

Signature:_____ Date: _____

I wish to have my face blocked from recognition in the photographs of me. _____ Initials

I, _____(Print full name), hereby give my permission to use my photographic likeness for marketing purposes including but not limited to print advertising, internet or television media. If I choose to have my face blocked from recognition in the photographs I have initialed such in the space above.

Signature:_____ Date: _____