Scoliosis Treatment Clinic
Dr. Chris Barker
6595 South Florida Ave #3
Lakeland Fl, 33813
863-940-3444

Scoliosis Corrective Patient Information:

Please complete the information requested to the best of your ability, this will give our Doctors the information they need to best understand your situation.

Patient/Guardian Name: _____

Address: _____

Phone: _____

Email Address: _____

Gender: _____

Date of Birth: _____ Age: _____

Height: _____ Weight: _____

Date Diagnosed with Scoliosis: _____

Who Diagnosed: _____

Degree of Curvature at time of initial diagnoses: _____

When diagnosis, what treatment did you do: _____

_____

What where the results: _____

When were your most current x-rays taken: _____

Degree of curvature on most current x-rays: _____

What is your current method of treatment: _____

_____

Any other health problems/concerns: _____

_____

Birth History: Vaginal / C-section / Forceps

Birth Complications: _____

_____

Major Trauma, Accidents or Falls: _____

_____

How did you hear about Dr. Chris Barker:_____

How is this affecting your life:_____

Intent / Description of Phone Consultation

I understand that this is a phone call consultation only and this is NOT meant to replace a complete examination or evaluation. The intent of this phone consultation is not diagnosis or treat any condition, but merely to review your case and discuss the available options, answer any questions, and the current treatment models. I understand that the doctor doesn't have all data necessary to make a complete diagnosis or prognosis regarding treatment, exams, x-rays and any other testing. I acknowledge that, by preliminarily reviewing any diagnostic imaging or having a pre-treatment consultation to determine whether it is appropriate for NCC to treat you, neither NCC nor Dr.Chris Barker, D.C, are accepting your case for treatment. I agree that my case will be accepted for treatment only if Dr. Barker and NCC provide a written plan agreeing to establish a doctor-patient relationship. Until that time, I agree that no doctor-patient relationship has been established by any preliminary review of any diagnostic imaging or a pre-treatment consultation even if I have been charged fees for such review or consultation. I further agree that the initial review or preliminary consultation with NCC is only for purposes of determining whether your case is appropriate for treatment performed by NCC and Dr. Barker.

Patient or Patient Guardian _____ Date _____