

Dear Parent,

Exam #: \_\_\_\_\_

This year's spinal screenings are scheduled for Tuesday, April 24, 2018. Please fill in the following information if you would like your child screened. These screenings should be performed every year. Return this form, with your signature, to the school nurse or teacher.

**YEARLY SPINAL CHECK UP and SCOLIOSIS SCREENING**

Child's Name (print) \_\_\_\_\_ School: ASSUMPTION

Address \_\_\_\_\_ Phone #: \_\_\_\_\_

Age \_\_\_\_\_ Male/Female, Birth Date \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Grade \_\_\_\_\_ Teacher \_\_\_\_\_

Please list any accident, broken bone, significant fall/jolt that may have affected your child's spine or posture (since their last spinal exam).

\_\_\_\_\_

\*Parent's signature \_\_\_\_\_

Do NOT write below this line - For office use only

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Head Tilt:	Normal _____	Left _____	Right _____
Ear Level:	Normal _____	Left _____	Right _____
Shoulder Level:	Normal _____	Left _____	Right _____
Hip Level:	Normal _____	Left _____	Right _____
Foot Turn Out:	Normal _____	Left _____	Right _____

Cervical Curve:	Normal _____	Increased _____	Decreased _____
Dorsal Curve:	Normal _____	Increased _____	Decreased _____
Lumbar Curve:	Normal _____	Increased _____	Decreased _____

Adam's Test: Mid Back \_\_\_ Low Back \_\_\_ Rt. High \_\_\_ Lt. High \_\_\_

Prone Raised Muscle Groups: Mid Back \_\_\_ Low Back \_\_\_, Rt. High \_\_\_ Lt. High \_\_\_  
Functional Short Leg: Rt. \_\_\_\_\_ Lt. \_\_\_\_\_

Examinations performed and analyzed by:  
J. Bartley Martinez, DC, DABCO. (Board Certified Chiropractic Orthopedist)

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