

SPINAL SCREENING FORM

Date of Screening _____

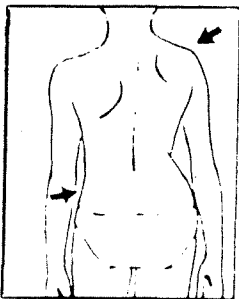
Sex _____

Name _____

Birthdate _____

School _____

Grade _____

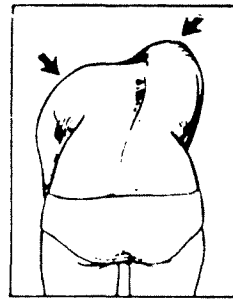


1. Shoulder Elevated

Right Left

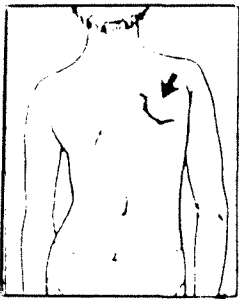
2. Pelvis Low

Right Left



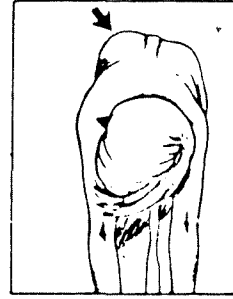
5. Rib Prominence

Right Left



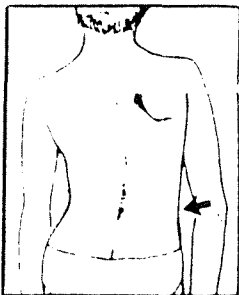
3. Scapular Prominence

Right Left



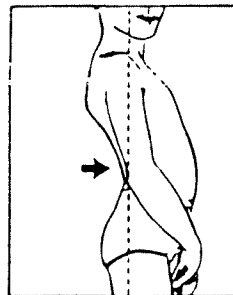
6. Lumbar Prominence

Right Left



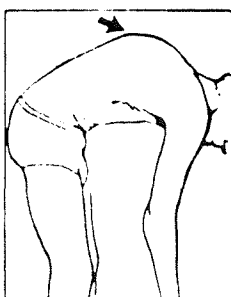
4. Decreased Arm/Trunk Space

Right Left



7. Lordosis Increased

Positive



8. Kyphosis Increased

Positive

For more information contact:

____Physician Referral Recommended

____Follow-up Received