

## AUTO ACCIDENT INFORMATION

Under Utah's no-fault law, if you are injured in an auto accident, regardless of fault, YOUR OWN INSURANCE company must pay for your medical benefits. These benefits are known as Personal Injury protection or "PIP." (Your vehicle repairs are covered by the at-fault drivers' insurance.) You must make a separate claim with your insurance for PIP benefits. You will have a minimum of \$3,000 for your medial needs.

If you were not at-fault, your insurance company will submit a bill to the company of the at-fault driver and will be reimbursed for the PIP benefits it has paid on your behalf.

**If you haven't made a claim with your insurance, please do so as soon as possible. When this is done your insurance will send you a PIP application that must be filled out and returned as soon as possible. Payments for your medial care will not be released until this is done.**

- You must maintain an active treatment plan for your Insurance to consider payment. Large gaps in treatment tell your insurance that your injuries may not require treatment; therefore, PIP benefits may be denied.
- If your injuries require treatment beyond your PIP benefits:
  - If not at-fault you can continue treatment, after PIP benefits have been exhausted, if you have signed a lien and have an attorney to settle your claims.
  - If you were at-fault, your insurance company will not pay past your PIP limit. At that point, your health insurance will need to be billed.

Please provide us with the following items as soon as possible:

- All insurance information including:
  - Insurance company
  - Adjuster Name, Phone #, Fax #
  - Claim #
- All medical care that you have received since your accident
- Attorney information
- Police report

**PLEASE FILL OUT AND RETURN PIP FORMS AS SOON AS POSSIBLE**

The Chiropractor, Dr. Bruce R. Lowry  
559 West State Road, Pleasant Grove, Utah 84062  
PH (801) 756-3888 FAX 801-471-2777

# The Chiropractor

Dr. Bruce R. Lowry

Today's Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ File# \_\_\_\_\_

Name: \_\_\_\_\_ ☐ Female ☐ Male

What do you prefer to be called: \_\_\_\_\_

Birthday: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Age: \_\_\_\_\_ SS: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Home Address: \_\_\_\_\_

(Street Address) (City) (State) (Zip Code)

Home#: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell#: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

EMAIL: \_\_\_\_\_

Employer: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

(Street Address) (City) (State) (Zip Code)

Occupation: \_\_\_\_\_ Phone# (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Spouse's Name: \_\_\_\_\_

Referred To This Office By: \_\_\_\_\_

Who Is Responsible For Your Bill, You and ☐ Spouse ☐ Parent ☐ Worker's Comp ☐ Insurance

In Event of Emergency: Name \_\_\_\_\_ Relation \_\_\_\_\_

Home#: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Other#: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Who is your Med Doctor: \_\_\_\_\_ Phone# (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Ins Company's Name \_\_\_\_\_ Phone# (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Address: \_\_\_\_\_

(Street Address) (City) (State) (Zip Code)

Group #: \_\_\_\_\_ Policy #: \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Insured SS#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Relation: \_\_\_\_\_ Date of Birth \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Are you covered under any other group or individual health policy through yourself or spouse?

☐ Yes ☐ No If yes, Company's Name: \_\_\_\_\_ Phone#: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Address: \_\_\_\_\_

(Street Address) (City) (State) (Zip Code)

Group #: \_\_\_\_\_ Policy#: \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Insured SS#: \_\_\_\_\_

Relation: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

- We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of service, unless other arrangements have been made. If account is not paid within 30 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection fees, and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims, and assign all insurance benefits directly to the provider.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my medical status.

Signature \_\_\_\_\_ Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

1. What was the date of the accident? \_\_\_\_\_
2. What time did the accident occur? \_\_\_\_\_ AM / PM
3. How many vehicles were involved in the accident? \_\_\_\_\_
4. What was the estimated damage to the vehicle you were in? \_\_\_\_\_
5. What Street or Intersection did the accident occur on? \_\_\_\_\_
6. What direction were you traveling in? North, South, East, West, Other \_\_\_\_\_
7. What city did the accident occur in? \_\_\_\_\_
8. What state did the accident occur in? \_\_\_\_\_
9. What type of impact was the auto accident? Rear End, T-Bone, Head on Other \_\_\_\_\_
10. Did your vehicle hit anything after the accident? if yes, please describe \_\_\_\_\_
11. **Where**, in the Vehicle were you sitting during the accident? \_\_\_\_\_
12. Did you know the accident was coming? NO YES Relaxed / Tense
13. What type of vehicle were you in? \_\_\_\_\_
14. What type of vehicle impacted yours? \_\_\_\_\_
15. At the time of the impact, how fast was your vehicle moving? \_\_\_\_\_
16. At the time of impact, how fast was the other vehicle moving? \_\_\_\_\_
17. During and after the crash what happened to your vehicle? (circle all that apply)
  - kept going straight
  - kept going straight hitting a car in front
  - was hit by another vehicle
  - spun around
  - spun around and hit a stationary object
  - hit a stationary object
18. Did you lose consciousness during the accident? NO YES
19. How was your head positioned during the accident? Up Down Turned Forward \_\_\_\_\_
20. How was your torso positioned during the accident? \_\_\_\_\_
21. Where were your hands positioned during the accident? \_\_\_\_\_
22. Did your head hit anything during the accident? NO YES, please describe \_\_\_\_\_
23. Did your face hit anything during the accident? NO YES, please describe \_\_\_\_\_
24. Did your shoulders hit anything in the accident? NO YES, please describe \_\_\_\_\_
25. Did your neck hit anything during the accident? NO YES, please describe \_\_\_\_\_
26. Did your chest hit anything during the accident? NO YES, please describe \_\_\_\_\_
27. Did your hips hit anything during the accident? NO YES, please describe \_\_\_\_\_

28. Did your knees hit anything during the accident? NO YES, please describe\_\_\_\_\_

29. Did your feet hit anything during the accident? NO YES, please describe\_\_\_\_\_

30. What kind of headrest was in your vehicle?

- movable fixed headrest
- non-movable fixed headrest
- no headrest

31. Where was the headrest positioned on your head? Top / Middle / Bottom / Other \_\_\_\_\_

32. Did you have your seatbelt on during the accident? NO YES

33. Did you slide out of your seatbelt during the accident? NO YES

34. What was damaged in/on your vehicle? (Circle all that apply)

- |                  |                    |                      |
|------------------|--------------------|----------------------|
| - windshield     | - rear bumper      | - mirror             |
| - steering wheel | - front bumper     | - knee bolster       |
| - dashboard      | - trunk            | - back right door    |
| - seat frame     | - front left door  |                      |
| - side window    | - front right door | - completely totaled |
| - rear window    | - back left door   |                      |

35. Choose the items that dented inward.

- |               |             |             |
|---------------|-------------|-------------|
| - floorboards | - side door | - dashboard |
|---------------|-------------|-------------|

36. Choose the doors that would not open as a result of the accident.

- |              |               |
|--------------|---------------|
| - front left | - front right |
| - rear left  | - rear right  |

37. Did you go to the hospital? (If no, why and do not answer 38-43)

\_\_\_\_\_

38. How did get to the hospital? \_\_\_\_\_

39. What was the name of the hospital? \_\_\_\_\_

40. Were you hospitalized over night? NO YES

41. Circle what you were prescribed at the hospital

- |                   |                   |              |
|-------------------|-------------------|--------------|
| - pain medication | - muscle relaxers | - neck brace |
|-------------------|-------------------|--------------|

42. Did you receive any stitches for any cuts at the hospital?

NO YES, please describe\_\_\_\_\_

43. Were x-rays taken at the hospital? NO YES, If yes, which area was taken?

Head, Neck, Mid-Back, Lower Back,  
Other \_\_\_\_\_

44. Was an MRI / CAT scan taken at the hospital? NO YES, If yes, which area was taken?

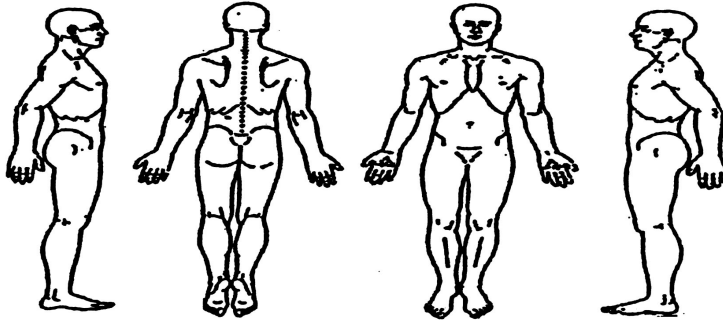
Head, Neck, Mid-Back, Lower Back,  
Other \_\_\_\_\_

# PATIENT INTAKE FORM

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

1. Is today's problem caused by: ☐ Auto Accident ☐ Workman's Compensation ☐ Neither

2. Indicate on the drawings below where you have pain/symptoms



3. How often do you experience your symptoms?

- ☐ Constantly (76-100% of the time) ☐ Occasionally (26-50% of the time)  
☐ Frequently (51-75% of the time) ☐ Intermittently (1-25% of the time)

4. How would you describe the type of pain?

- ☐ Sharp ☐ Shooting ☐ Shooting with motion  
☐ Dull ☐ Stiff ☐ Stabbing with motion  
☐ Diffuse ☐ Numb ☐ Electric like with motion  
☐ Achy ☐ Tingly ☐ Other: \_\_\_\_\_  
☐ Burning ☐ Sharp with motion ☐ \_\_\_\_\_

5. How are your symptoms changing with time?

- ☐ Getting Worse ☐ Staying the Same ☐ Getting Better

6. Using a scale from 0-10 (10 being the worst), how would you rate your problem?

0 1 2 3 4 5 6 7 8 9 10 (Please circle)

7. How much has the problem interfered with your work?

- ☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

8. How much has the problem interfered with your social activities?

- ☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

9. Who else have you seen for your problem?

- ☐ Chiropractor ☐ Neurologist ☐ Primary Care Physician  
☐ ER physician ☐ Orthopedist ☐ Other: \_\_\_\_\_  
☐ Massage Therapist ☐ Physical Therapist ☐ No one

10. How long have you had this problem? \_\_\_\_\_

11. How do you think your problem began? \_\_\_\_\_

12. Do you consider this problem to be severe? ☐ Yes ☐ Yes, at times ☐ No

13. What aggravates your problem? \_\_\_\_\_

What makes it feel better? \_\_\_\_\_

14. What concerns you the most about your problem? What does it prevent you from doing?

15. What is your: Height \_\_\_\_\_ Weight \_\_\_\_\_ Age \_\_\_\_\_

16. How would you rate your overall Health?

- ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

17. What type of exercise do you do?

- ☐ Strenuous ☐ Moderate ☐ Light ☐ None

18. Indicate if you have any immediate family members with any of the following:

- ☐ Rheumatoid Arthritis ☐ Diabetes ☐ Lupus  
☐ Heart Problems ☐ Cancer ☐ ALS

## MEDICAL HISTORY

**19. For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.**

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Past   Present</b><br><input type="checkbox"/> <input type="checkbox"/> Headaches<br><input type="checkbox"/> <input type="checkbox"/> Neck Pain<br><input type="checkbox"/> <input type="checkbox"/> Upper Back Pain<br><input type="checkbox"/> <input type="checkbox"/> Mid Back Pain<br><input type="checkbox"/> <input type="checkbox"/> Low Back Pain<br><input type="checkbox"/> <input type="checkbox"/> Shoulder Pain<br><input type="checkbox"/> <input type="checkbox"/> Elbow/Upper Arm Pain<br><input type="checkbox"/> <input type="checkbox"/> Wrist Pain<br><input type="checkbox"/> <input type="checkbox"/> Hand Pain<br><input type="checkbox"/> <input type="checkbox"/> Hip Pain<br><input type="checkbox"/> <input type="checkbox"/> Upper Leg Pain<br><input type="checkbox"/> <input type="checkbox"/> Knee Pain<br><input type="checkbox"/> <input type="checkbox"/> Ankle/Foot Pain<br><input type="checkbox"/> <input type="checkbox"/> Jaw Pain<br><input type="checkbox"/> <input type="checkbox"/> Joint Pain/Stiffness<br><input type="checkbox"/> <input type="checkbox"/> Arthritis<br><input type="checkbox"/> <input type="checkbox"/> Rheumatoid Arthritis<br><input type="checkbox"/> <input type="checkbox"/> Cancer<br><input type="checkbox"/> <input type="checkbox"/> Tumor<br><input type="checkbox"/> <input type="checkbox"/> Asthma<br><input type="checkbox"/> <input type="checkbox"/> Chronic Sinusitis<br><input type="checkbox"/> <input type="checkbox"/> Other: _____ | <b>Past   Present</b><br><input type="checkbox"/> <input type="checkbox"/> High Blood Pressure<br><input type="checkbox"/> <input type="checkbox"/> Heart Attack<br><input type="checkbox"/> <input type="checkbox"/> Chest Pains<br><input type="checkbox"/> <input type="checkbox"/> Stroke<br><input type="checkbox"/> <input type="checkbox"/> Angina<br><input type="checkbox"/> <input type="checkbox"/> Kidney Stones<br><input type="checkbox"/> <input type="checkbox"/> Kidney Disorders<br><input type="checkbox"/> <input type="checkbox"/> Bladder Infection<br><input type="checkbox"/> <input type="checkbox"/> Painful Urination<br><input type="checkbox"/> <input type="checkbox"/> Loss of Bladder Control<br><input type="checkbox"/> <input type="checkbox"/> Prostate Problems<br><input type="checkbox"/> <input type="checkbox"/> Abnormal Weight Gain/Loss<br><input type="checkbox"/> <input type="checkbox"/> Loss of Appetite<br><input type="checkbox"/> <input type="checkbox"/> Abdominal Pain<br><input type="checkbox"/> <input type="checkbox"/> Ulcer<br><input type="checkbox"/> <input type="checkbox"/> Hepatitis<br><input type="checkbox"/> <input type="checkbox"/> Liver/Gall Bladder Disorder<br><input type="checkbox"/> <input type="checkbox"/> General Fatigue<br><input type="checkbox"/> <input type="checkbox"/> Muscular Incoordination<br><input type="checkbox"/> <input type="checkbox"/> Visual Disturbances<br><input type="checkbox"/> <input type="checkbox"/> Dizziness | <b>Past   Present</b><br><input type="checkbox"/> <input type="checkbox"/> Diabetes<br><input type="checkbox"/> <input type="checkbox"/> Excessive Thirst<br><input type="checkbox"/> <input type="checkbox"/> Frequent Urination<br><input type="checkbox"/> <input type="checkbox"/> Smoking/Tobacco Use<br><input type="checkbox"/> <input type="checkbox"/> Drug/Alcohol Dependence<br><input type="checkbox"/> <input type="checkbox"/> Allergies<br><input type="checkbox"/> <input type="checkbox"/> Depression<br><input type="checkbox"/> <input type="checkbox"/> Systemic Lupus<br><input type="checkbox"/> <input type="checkbox"/> Epilepsy<br><input type="checkbox"/> <input type="checkbox"/> Dermatitis/Eczema/Rash<br><input type="checkbox"/> <input type="checkbox"/> HIV/AIDS<br><br><b>For Females Only</b><br><input type="checkbox"/> <input type="checkbox"/> Birth Control Pills<br><input type="checkbox"/> <input type="checkbox"/> Hormonal Replacement<br><input type="checkbox"/> <input type="checkbox"/> Pregnancy |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

**20. List all prescription medications you are currently taking:** \_\_\_\_\_

**21. List all of the over-the-counter medications you are currently taking:** \_\_\_\_\_

**22. List all surgical procedures you have had:** \_\_\_\_\_

**23. What activities do you do at work?**

|                |                                          |                                       |                                              |
|----------------|------------------------------------------|---------------------------------------|----------------------------------------------|
| Sit:           | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half the day | <input type="checkbox"/> A little of the day |
| Stand:         | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half the day | <input type="checkbox"/> A little of the day |
| Computer work: | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half the day | <input type="checkbox"/> A little of the day |
| On the phone:  | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half the day | <input type="checkbox"/> A little of the day |

**24. What activities do you do outside of work?** \_\_\_\_\_

**25. Have you ever been hospitalized?**    ☐ No    ☐ Yes    if yes, why \_\_\_\_\_

**26. Have you had significant past trauma?**    ☐ No    ☐ Yes

**27. Anything else pertinent to your visit today?** \_\_\_\_\_

**Patient Signature** \_\_\_\_\_ **Date:** \_\_\_\_\_

# SYMPTOM INTENSITY AND FREQUENCY

Name: \_\_\_\_\_

Date: \_\_\_\_\_

## CURRENT PAIN INTENSITY LEVELS

Describe on a scale of 1-10 how intense your pain or symptoms are. This includes the amount of aching, soreness, hurting, pain, numbness, and/or tingling levels present currently. A zero (0) indicates that no symptoms exist. **1-3 pain** level is a minimum level and indicates that your pain is an annoyance only. A **4 pain** is a slight level, where pain doing activity begins to cause some disability. A **5-7 pain** is moderate in severity and has to restrict or limit your activity ability to a significant degree. A **8-10 pain** level is severe and indicates that your pain intensity is to point where you have complete inability to perform some tasks.

**Circle the box that best describes your symptoms today**

| Pain Intensity | None | MINIMAL<br>Discomfort/Ache/Stiff |  |  | SLIGHT-TO-MODERATE<br>Hurts/Sore/Bearable Sensation |  |  | SEVERE<br>Sharp/Intense Pain |  |  |
|----------------|------|----------------------------------|--|--|-----------------------------------------------------|--|--|------------------------------|--|--|
|----------------|------|----------------------------------|--|--|-----------------------------------------------------|--|--|------------------------------|--|--|

|                    |   |   |   |   |   |   |   |   |   |   |    |
|--------------------|---|---|---|---|---|---|---|---|---|---|----|
| Headache           | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Neck Pain/Soreness | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Arm/Hand Symptoms  | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Mid Back Pain      | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Low back Pain      | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Leg/Foot Symptoms  | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Other _____        | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

## CURRENT PAIN FREQUENCY LEVELS

Describe how frequently you have symptoms such as pain, numbness, and tingling in the respected areas. A zero (0) indicates that no symptoms exist. **1-3 frequency** level is a minimum level and indicates that your symptoms are occasional. A **4 –6 frequency** is a moderate level, meaning that symptoms are intermittent, coming and going. A **7-8 frequency** is an indication that the symptoms are present more often than not but still not constant. A **9-10 frequency** level is severe and indicates that your symptoms are constant.

**Circle the box that represents the average percentage of time you have symptoms**

| Pain Frequency | None | Occasional |  |  | Intermittent |  |  | Frequent |  | Constant |  |
|----------------|------|------------|--|--|--------------|--|--|----------|--|----------|--|
|----------------|------|------------|--|--|--------------|--|--|----------|--|----------|--|

|                    |    |     |     |     |     |     |     |     |     |     |      |
|--------------------|----|-----|-----|-----|-----|-----|-----|-----|-----|-----|------|
| Neck pain/soreness | 0% | 10% | 20% | 30% | 40% | 50% | 60% | 70% | 80% | 90% | 100% |
| Arm/Hand Symptoms  | 0% | 10% | 20% | 30% | 40% | 50% | 60% | 70% | 80% | 90% | 100% |
| Mid-back Pain      | 0% | 10% | 20% | 30% | 40% | 50% | 60% | 70% | 80% | 90% | 100% |
| Low Back Pain      | 0% | 10% | 20% | 30% | 40% | 50% | 60% | 70% | 80% | 90% | 100% |
| Leg/Foot Symptoms  | 0% | 10% | 20% | 30% | 40% | 50% | 60% | 70% | 80% | 90% | 100% |

## CURRENT PAIN FREQUENCY LEVELS

How frequently do you have headaches/migraines currently? Per week: 0 1 2 3 4 5 6 7 1x/month 2x/month

How long do they typically last? \_\_\_\_\_ hours all day several days \_\_\_\_\_

What triggers your headaches? \_\_\_\_\_

Are they controllable? (If so, what helps?) \_\_\_\_\_

Where are they located? \_\_\_\_\_

## LOW BACK DISABILITY QUESTIONNAIRE (REVISED OSWESTRY)

This questionnaire has been designed to give the doctor information as to how your back pain has affected your ability to manage in everyday life. **Please answer every section and mark in each section only ONE box** which applies to you. We realize you may consider that two of the statements in any one section relate to you, but **please just mark the box which MOST CLOSELY describes your problem.**

### Section 1 - Pain Intensity

- ☐ I can tolerate the pain without having to use painkillers.
- ☐ The pain is bad but I can manage without taking painkillers.
- ☐ Painkillers give complete relief from pain.
- ☐ Painkillers give moderate relief from pain.
- ☐ Painkillers give very little relief from pain.
- ☐ Painkillers have no effect on the pain and I do not use them.

### Section 2 -- Personal Care (Washing, Dressing, etc.)

- ☐ I can look after myself normally without causing extra pain.
- ☐ I can look after myself normally but it causes extra pain.
- ☐ It is painful to look after myself and I am slow and careful.
- ☐ I need some help but manage most of my personal care.
- ☐ I need help every day in most aspects of self care.
- ☐ I do not get dressed, I wash with difficulty and stay in bed.

### Section 3 – Lifting

- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights but it gives extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on a table.
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can lift very light weights.
- ☐ I cannot lift or carry anything at all.

### Section 4 – Walking

- ☐ Pain does not prevent me from walking any distance.
- ☐ Pain prevents me from walking more than one mile.
- ☐ Pain prevents me from walking more than one-half mile.
- ☐ Pain prevents me from walking more than one-quarter mile.
- ☐ I can only walk using a stick or crutches.
- ☐ I am in bed most of the time and have to crawl to the toilet.

### Section 5 -- Sitting

- ☐ I can sit in any chair as long as I like
- ☐ I can only sit in my favorite chair as long as I like
- ☐ Pain prevents me from sitting more than one hour.
- ☐ Pain prevents me from sitting more than 30 minutes.
- ☐ Pain prevents me from sitting more than 10 minutes.
- ☐ Pain prevents me from sitting almost all the time.

Comments \_\_\_\_\_

### Section 6 – Standing

- ☐ I can stand as long as I want without extra pain.
- ☐ I can stand as long as I want but it gives extra pain.
- ☐ Pain prevents me from standing more than 1 hour.
- ☐ Pain prevents me from standing more than 30 minutes.
- ☐ Pain prevents me from standing more than 10 minutes.
- ☐ Pain prevents me from standing at all.

### Section 7 -- Sleeping

- ☐ Pain does not prevent me from sleeping well.
- ☐ I can sleep well only by using tablets.
- ☐ Even when I take tablets I have less than 6 hours sleep.
- ☐ Even when I take tablets I have less than 4 hours sleep.
- ☐ Even when I take tablets I have less than 2 hours sleep.
- ☐ Pain prevents me from sleeping at all.

### Section 8 – Social Life

- ☐ My social life is normal and gives me no extra pain.
- ☐ My social life is normal but increases the degree of pain.
- ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. dancing.
- ☐ Pain has restricted my social life and I do not go out as often.
- ☐ Pain has restricted my social life to my home.
- ☐ I have no social life because of pain.

### Section 9 – Traveling

- ☐ I can travel anywhere without extra pain.
- ☐ I can travel anywhere but it gives me extra pain.
- ☐ Pain is bad but I manage journeys over 2 hours.
- ☐ Pain is bad but I manage journeys less than 1 hour.
- ☐ Pain restricts me to short necessary journeys under 30 minutes.
- ☐ Pain prevents me from traveling except to the doctor or hospital.

### Section 10 – Changing Degree of Pain

- ☐ My pain is rapidly getting better.
- ☐ My pain fluctuates but overall is definitely getting better.
- ☐ My pain seems to be getting better but improvement is slow at the present.
- ☐ My pain is neither getting better nor worse.
- ☐ My pain is gradually worsening.
- ☐ My pain is rapidly worsening.

Scoring: Questions are scored on a vertical scale of 0-5. Total scores and multiply by 2. Divide by number of sections answered multiplied by 10. A score of 22% or more is considered significant activities of daily living disability.

(Score x 2) / (Sections x 10) = %ADL

## NECK DISABILITY INDEX

This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage in everyday life. **Please answer every section and mark in each section only ONE box** which applies to you. We realize you may consider that two of the statements in any one section relate to you, but **please just mark the box which MOST CLOSELY describes your problem.**

### Section 1 - Pain Intensity

- ☐ I have no pain at the moment.
- ☐ The pain is very mild at the moment.
- ☐ The pain is moderate at the moment.
- ☐ The pain is fairly severe at the moment.
- ☐ The pain is very severe at the moment.
- ☐ The pain is the worst imaginable at the moment.

### Section 2 -- Personal Care (Washing, Dressing, etc.)

- ☐ I can look after myself normally without causing extra pain.
- ☐ I can look after myself normally but it causes extra pain.
- ☐ It is painful to look after myself and I am slow and careful.
- ☐ I need some help but manage most of my personal care.
- ☐ I need help every day in most aspects of self care.
- ☐ I do not get dressed, I wash with difficulty and stay in bed.

### Section 3 – Lifting

- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights but it gives extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on a table.
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can lift very light weights.
- ☐ I cannot lift or carry anything at all.

### Section 4 – Reading

- ☐ I can read as much as I want to with no pain in my neck.
- ☐ I can read as much as I want to with slight pain in my neck.
- ☐ I can read as much as I want with moderate pain.
- ☐ I can't read as much as I want because of moderate pain in my neck.
- ☐ I can hardly read at all because of severe pain in my neck.
- ☐ I cannot read at all.

### Section 5-Headaches

- ☐ I have no headaches at all.
- ☐ I have slight headaches which come infrequently.
- ☐ I have slight headaches which come frequently.
- ☐ I have moderate headaches which come infrequently.
- ☐ I have severe headaches which come frequently.
- ☐ I have headaches almost all the time.

### Section 6 – Concentration

- ☐ I can concentrate fully when I want to with no difficulty.
- ☐ I can concentrate fully when I want to with slight difficulty.
- ☐ I have a fair degree of difficulty in concentrating when I want to.
- ☐ I have a lot of difficulty in concentrating when I want to.
- ☐ I have a great deal of difficulty in concentrating when I want to.
- ☐ I cannot concentrate at all.

### Section 7—Work

- ☐ I can do as much work as I want to.
- ☐ I can only do my usual work, but no more.
- ☐ I can do most of my usual work, but no more.
- ☐ I cannot do my usual work.
- ☐ I can hardly do any work at all.
- ☐ I can't do any work at all.

### Section 8 – Driving

- ☐ I drive my car without any neck pain.
- ☐ I can drive my car as long as I want with slight pain in my neck.
- ☐ I can drive my car as long as I want with moderate pain in my neck.
- ☐ I can't drive my car as long as I want because of moderate pain in my neck.
- ☐ I can hardly drive my car at all because of severe pain in my neck.
- ☐ I can't drive my car at all.

### Section 9 – Sleeping

- ☐ I have no trouble sleeping.
- ☐ My sleep is slightly disturbed (less than 1 hr. sleepless).
- ☐ My sleep is moderately disturbed (1-2 hrs. sleepless).
- ☐ My sleep is moderately disturbed (2-3 hrs. sleepless).
- ☐ My sleep is greatly disturbed (3-4 hrs. sleepless).
- ☐ My sleep is completely disturbed (5-7 hrs. sleepless).

### Section 10 – Recreation

- ☐ I am able to engage in all my recreation activities with no neck pain at all.
- ☐ I am able to engage in all my recreation activities, with some pain in my neck.
- ☐ I am able to engage in most, but not all of my usual recreation activities because of pain in my neck.
- ☐ I am able to engage in a few of my usual recreation activities because of pain in my neck.
- ☐ I can hardly do any recreation activities because of pain in my neck.
- ☐ I can't do any recreation activities at all.

Scoring: Questions are scored on a vertical scale of 0-5. Total scores and multiply by 2. Divide by number of sections answered multiplied by 10. A score of 22% or more is considered a significant activities of daily living disability.

(Score    x 2) / (    Sections x 10) =    L                      %AD

**Comments** \_\_\_\_\_

## INFORMED CONSENT FOR CHIROPRACTIC CARE

This document constitutes informed consent for chiropractic services.

When a patient seeks chiropractic health care, and we accept that patient for such care, it is essential for both to be working towards the same goal. This prevents confusion and disappointment.

**A *vertebral subluxation* is a mechanical interference by the spinal bones to the transmission of energy and information over nerve pathways.**

The only goal of this office is to keep the body as free from vertebral subluxations as possible. This is due to our absolute conviction that every human being functions better on all levels when fewer vertebral subluxations are present.

We do not offer to examine, diagnose, treat or give advice about any disease or condition, whether physical, mental, or emotional other than vertebral subluxation. However, if during the course of chiropractic spinal examination we encounter non-chiropractic or unusual findings, we will so advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

It is the responsibility of each individual to keep us informed and updated regarding any accidents, injuries, surgeries, illnesses, medication, or other factors that could relate to the safety of receiving our services.

The practice of medicine, in the practice of other clinical therapies, there are some risks to treatment. If I receive chiropractic treatment, the most common risks are temporary aggravation of my condition or soreness. Rarer risks include, but are not limited to, fracture, dislocations, sprains/strains, burns and aggravation of disc injuries. There are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke; rather, recent studies indicate that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there is a stroke already in process. However, you are being informed of this reported association because a stroke may cause serious neurological impairment. The possibility of such injuries occurring in association with upper cervical adjustment is extremely remote.

I do not expect the practitioner to be able to anticipate and explain all risks and complications, and I wish to rely on him/her to exercise judgment during the course of the procedure which he or she feels at the time, based on the facts then known is in my best interest.

I acknowledge that during the course of my care, I or the person named below for whom I am legally responsible, may receive chiropractic adjustments and other procedures including various modes of physiotherapy and diagnostic x-rays.

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Patient's Name (PLEASE PRINT)

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Today's Date

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Signature of Patient (or guardian if patient is minor)

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Today's Date

**The Chiropractor, Dr. Bruce R. Lowry**  
559 West State Road, Pleasant Grove, Utah 84062  
(801) 756-3888

# ACTIVITY QUESTIONNAIRE

PATIENT NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

Check only the activities below that affect you currently. Be specific and indicate whether your pain, weakness, stiffness, or other symptoms, while doing the activity, annoy you, slow you down, or prevent (unable to do) your ability to perform the activity.

| ACTIVITY DESCRIPTION                              | ANNOY ONLY | SLOWS DOWN | HARD TO DO | UNABLE TO DO |
|---------------------------------------------------|------------|------------|------------|--------------|
| Bending head and neck downward                    |            |            |            |              |
| Bending head and neck upward                      |            |            |            |              |
| Working at computer station                       |            |            |            |              |
| Driving car                                       |            |            |            |              |
| Sitting                                           |            |            |            |              |
| Working at desk                                   |            |            |            |              |
| Lifting/reaching hands over level of shoulder     |            |            |            |              |
| Lifting/reaching hands over level of head         |            |            |            |              |
| Lifting at work                                   |            |            |            |              |
| Doing reaching activities                         |            |            |            |              |
| Combing/brushing hair                             |            |            |            |              |
| Typing on a keyboard                              |            |            |            |              |
| Carrying objects in hand                          |            |            |            |              |
| Gripping objects or using wrists or hands         |            |            |            |              |
| Sleeping                                          |            |            |            |              |
| Recreational/sports/hobby activities              |            |            |            |              |
| Doing housework (dishes, vacuuming)               |            |            |            |              |
| Doing gardening                                   |            |            |            |              |
| Stooping/bending low back                         |            |            |            |              |
| Twisting torso/back                               |            |            |            |              |
| Crouching/kneeling                                |            |            |            |              |
| Walking over <b>even</b> ground                   |            |            |            |              |
| Walking over <b>uneven</b> ground (rough terrain) |            |            |            |              |
| Pivoting body                                     |            |            |            |              |
| Standing                                          |            |            |            |              |
| Pushing/pulling                                   |            |            |            |              |
| Climbing                                          |            |            |            |              |
| Lifting at home                                   |            |            |            |              |
| Intimate Activities                               |            |            |            |              |
| Other                                             |            |            |            |              |

# The Chiropractor, Dr. Bruce R. Lowry

559 West State Street, Pleasant Grove UT 84062

**THIS NOTICE DESCRIBES HOW CHIROPRACTIC AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

In the course of your care as a patient at our Clinic we may use or disclose personal and health related information about you in the following ways:

- Your protected health information, including your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.
- Your health care records as well as your billing records may be disclosed to another party, such as an insurance carrier, and HMO, PPO, or your employer, if they are or may be responsible for the payment of services provided to you.
- Your name, address, phone number, and your health care records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or the health related information that may be of interest to you.

You have a right to request restrictions on our use of your protected health information for treatment, payment and operations purposes. Such requests are not automatic and require the agreement of this office.

If you are not home to receive an appointment reminder or other related information, a message may be left on your answering machine or with a person in your household. You have the right to confidential communications and to request restrictions relative to such contact. You also have the right to be contacted by alternative means or at alternative locations.

We are permitted and may be required to use or disclose your health information without your authorization in these following circumstances:

- If we provide health care services to you in an emergency.
- If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
- If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.
- If we are ordered by the courts or another appropriate agency.

You have a right to receive an accounting of any such disclosures made by this office.

Any use or disclosure of your protected health information, other than as outlined above, will only be made upon your written authorization. If you provide an authorization for release of information you have the right to revoke that authorization at a later date.

Information that we use or disclose based on this privacy notice may be subject to redisclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

We normally provide information about your health to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your health care or about the status of your account. If you would like to receive this information at an address other than your home or, if you would like the information in a specific form please advise us in writing as to your preferences.

You have the right to inspect and /or copy your health information for as long as the information remains in our files. In addition you have the right to request an amendment to your health information. Requests to inspect, copy or amend your health related information should be provided to us in writing.

We are required by state and federal law to maintain the privacy of your patient file and the health protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information. We are further required by law to abide by the terms of this notice while it is in effect.

We reserve the right to alter or amend the terms of this privacy notice we will notify you in writing as soon as possible following the changes. Any change in our privacy notice will apply for all of your health information in our files.

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If you have a complaint, or if you would like further information regarding our privacy notice, our privacy practices or any aspect of our privacy activities you should contact:

Dr. Bruce R. Lowry (801) 756-3888  
559 West State Street Pleasant Grove, UT 84062  
Privacy/Security Officer

You also have the right to lodge a complaint with the Secretary of the Department of Health and Human Services. If you choose to lodge a complaint with this office or with the Secretary your care will continue and you will not be disadvantaged by this office or our staff in any manner whatsoever.

This notice is effective as of April 14, 2003. This notice, and any alterations of amendments made hereto will expire seven years after the date upon which the patient record was created. My signature acknowledges that I have received a copy of this notice.

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Name (Printed)

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Signature

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Date

If you are a minor, or if you are being represented by another party, please provide the appropriate person's:

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Name (Printed)

---

Signature

---

Date

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Relationship to the patient

# The Chiropractor

Dr. Bruce R. Lowry

IRREVOCABLE ASSIGNMENT, DIRECTION  
AND AUTHORITY TO PAY MEDICAL EXPENSES

**PATIENT SECTION:**

I hereby irrevocably assign, transfer and set over to The Chiropractor, Dr. Bruce R. Lowry such sums as may be due and owing for medical/chiropractic services rendered, including interest, and to be rendered hereafter to me, or to the person(s) of \_\_\_\_\_, by reason of the accident of \_\_\_\_\_, 20\_\_\_\_. I hereby irrevocably authorize and direct any person or company having or receiving money due me on such a claim, including my attorney, to pay The Chiropractor the unpaid balance of their bill for all professional services rendered to me or to the above-named person(s) before distributing any money to me. This is a direct and irrevocable assignment of rights and benefits under this claim.

I fully understand and expressly acknowledge that I am personally responsible and liable for the payment in full for services rendered by The Chiropractor to me or the above-named persons. Payment to the clinic is not contingent upon obtaining any funds from any third party who may be responsible for my injuries. This agreement is made solely for The Chiropractor's protection and in consideration for their awaiting payment. I have been advised that if I do not wish to cooperate in protecting The Chiropractor's interest, the clinic will not await payment but may declare the entire balance due and payable by me. In the event this agreement is litigated, shall the clinic prevail, I agree to pay all collection, attorney, and court costs as well as interest charges at the rate of 1 ½% per month from the date of beginning treatment.

I acknowledge my agreement to this request by signing below.

\_\_\_\_\_  
Date

\_\_\_\_\_  
*Patient or Guardian Signature*

**ACKNOWLEDGMENT AND RECEIPT OF ASSIGNMENT**

The undersigned insurance company/attorney does hereby acknowledge receipt of a copy of the above assignment and does agree that prior to the payments of any monies to the above-named patient or patient's guardian, after first subtracting from said funds any attorney's fees and costs due and owing as a direct result of representation of the client on the claim which resulted in the injuries being treated at the above named clinic, shall pay The Chiropractor all outstanding bills for professional services, if any, directly to The Chiropractor, 559 W State Road, UT 84062.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Ins. Co. Rep. / Attorney

\_\_\_\_\_  
Print First and Last Name

\_\_\_\_\_  
Insurance Co. / Law Firm Name