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 finical 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.

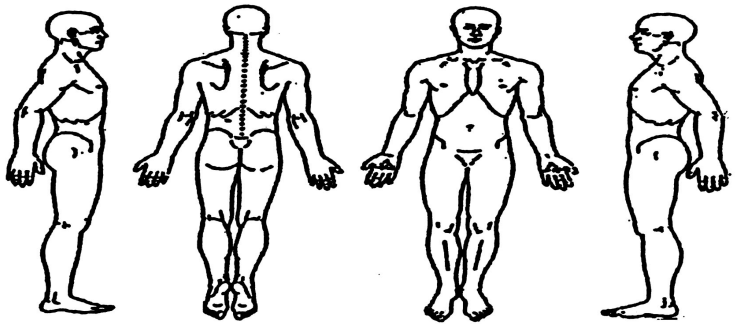
Signature_____ Date_____/_____/_____

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.

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

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:	□ Most of the day	□ Half the day	□ A little of the day
Stand:	□ Most of the day	□ Half the day	□ A little of the day
Computer work:	□ Most of the day	□ Half the day	□ A little of the day
On the phone:	□ Most of the day	□ Half the day	□ 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** Discomfort/Ache/Stiff			**SLIGHT-TO-MODERATE** Hurts/Sore/Bearable Sensation			**SEVERE** 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? _____

Patient's Name_____ Date_____

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

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

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

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

Section 3 – Lifting

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

Section 4 – Walking

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

Section 5 -- Sitting

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

Comments_____

Reference: Fairbank, Physiotherapy 1981; 66(8): 271-3, Hudson-Cook. In Roland, Jenner (eds.), Back Pain New Approaches To Rehabilitation & Education. Manchester Univ Press, Manchester 1989: 187-204

Section 6 – Standing

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

Section 7 -- Sleeping

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

Section 8 – Social Life

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

Section 9 – Traveling

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

Section 10 – Changing Degree of Pain

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

Patient's Name_____ Date_____

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

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

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

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

Section 3 – Lifting

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

Section 4 – Reading

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

Section 5-Headaches

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

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

Section 6 – Concentration

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

Section 7—Work

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

Section 8 – Driving

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

Section 9 – Sleeping

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

Section 10 – Recreation

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

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.

_____ _____

Patient's Name **(PLEASE PRINT)** Today's Date

_____ _____

Signature of Patient (or guardian if patient is minor) Today's Date

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

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 DESCLOSED 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 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.

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.

_____
Name (Printed)

_____ _____
Signature Date

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

_____
Name (Printed)

_____ _____
Signature Date

_____
Relationship to the patient