

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.

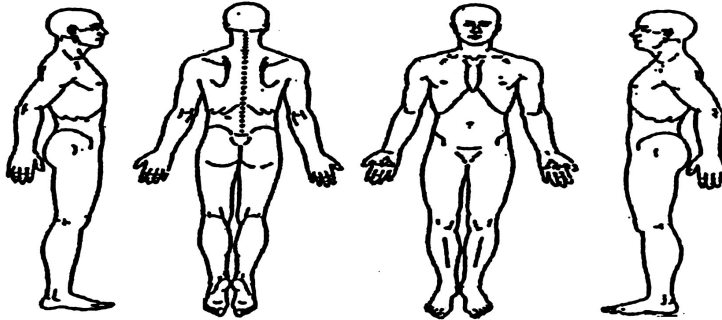
Signature _____ Date _____ / _____ / _____

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	For Females Only	
☐	☐ Ankle/Foot Pain	☐	☐ Loss of Appetite		
☐	☐ 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		
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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	
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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? _____

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 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.

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