

# Bowlby Chiropractic

---

## *New Patient History*

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

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

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_

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

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Marital Status:

*Single*

*Divorced*

*Married*

*Other*

Spouse's Name: \_\_\_\_\_ Children: 0 1 2 3 4 5+

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

Work Address: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Emergency contact name and number: \_\_\_\_\_

**Who may we thank for referring you:** \_\_\_\_\_

### *Insurance Information:*

Is your condition due to:

An Auto Accident

A Personal Injury

Work Injury

Health Insurance Company \_\_\_\_\_

Policy # \_\_\_\_\_

Spouse's Insurance Company \_\_\_\_\_

Policy # \_\_\_\_\_

Please sign here to authorization the release of records to your insurance carrier

**X** \_\_\_\_\_ **Date:** \_\_\_\_\_

[Turn Over]

# Bowlby Chiropractic

---

Please begin by letting us know what symptoms are giving you trouble.  
Circle any and all that apply.

1. Misc:

- Headaches
- TMJ

2. Spinal:

- Neck Pain
- Mid Back Pain
- Low Back Pain
- Neck Stiffness
- Mid Back Stiffness
- Low Back Stiffness

3. Upper:

- Left Shoulder Pain
- Right Shoulder Pain
- Left Arm Pain
- Right Arm Pain
- Left Wrist Pain
- Right Wrist Pain
- Left Hand Pain
- Right Hand Pain
- Radiating Pain to the left Shoulder
- Radiating Pain to the right Shoulder
- Radiating Pain to the left Arm
- Radiating Pain to the right Arm
- Numbness and Tingling* into the left Hand
- Numbness and Tingling* into the right Hand

4. Lower:

- Back left hip pain
- Back right hip pain
- Left Hip Pain
- Right Hip Pain
- Left Leg Pain
- Right Leg Pain
- Left Knee Pain
- Right Knee Pain
- Left Foot Pain
- Right Foot Pain
- Radiating Pain into the left Buttocks
- Radiating Pain into the right Buttocks
- Radiating Pain into the left Leg
- Radiating Pain into the right Leg
- Radiating Pain into left Foot
- Radiating Pain into right Foot
- Numbness and Tingling* into left Foot
- Numbness and Tingling* into right Foot

5. Other Symptoms: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

# Bowlby Chiropractic

---

6. About when did your symptoms begin? \_\_\_\_\_

7. How did your symptoms begin?

- |                                                                  |                                      |
|------------------------------------------------------------------|--------------------------------------|
| <input type="checkbox"/> Not doing anything at the time of onset | <input type="checkbox"/> Fell        |
| <input type="checkbox"/> Motor Vehicle Accident                  | <input type="checkbox"/> Lifting     |
| <input type="checkbox"/> Work Injury                             | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Overexertion                            | _____                                |
| <input type="checkbox"/> Strenuous Position                      |                                      |

8. How soon did the symptoms come on?

- |                                            |                                           |
|--------------------------------------------|-------------------------------------------|
| <input type="checkbox"/> Immediately       | <input type="checkbox"/> Slowly over time |
| <input type="checkbox"/> A week Later      | <input type="checkbox"/> A few Days Later |
| <input type="checkbox"/> A Few Hours Later |                                           |

9. Have you ever experienced these symptoms before?

- Yes \_\_\_\_\_
- No \_\_\_\_\_ (If 'Yes' please give an example and date)

10. What seems to **aggravate** your condition?

- |                                   |                                       |
|-----------------------------------|---------------------------------------|
| <input type="checkbox"/> Nothing  | <input type="checkbox"/> Sitting      |
| <input type="checkbox"/> Coughing | <input type="checkbox"/> Standing     |
| <input type="checkbox"/> Bending  | <input type="checkbox"/> Pulling      |
| <input type="checkbox"/> Lifting  | <input type="checkbox"/> Turning      |
| <input type="checkbox"/> Walking  | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Reaching |                                       |

11. What seems to **alleviate** your condition?

- |                                     |                                           |
|-------------------------------------|-------------------------------------------|
| <input type="checkbox"/> Nothing    | <input type="checkbox"/> Standing         |
| <input type="checkbox"/> Rest       | <input type="checkbox"/> Ice              |
| <input type="checkbox"/> Sitting    | <input type="checkbox"/> Heat             |
| <input type="checkbox"/> Stretching | <input type="checkbox"/> Medication _____ |
| <input type="checkbox"/> Exercise   | <input type="checkbox"/> Other _____      |

12. How would you **characterize** your pain? *(Please check all that apply)*

- |                                   |                                      |
|-----------------------------------|--------------------------------------|
| <input type="checkbox"/> Burning  | <input type="checkbox"/> Aching      |
| <input type="checkbox"/> Dull     | <input type="checkbox"/> Throbbing   |
| <input type="checkbox"/> Sharp    | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Shooting |                                      |

# Bowlby Chiropractic

---

13. Does your pain **radiate** to any of the following areas?

- |                                         |                                        |
|-----------------------------------------|----------------------------------------|
| <input type="checkbox"/> None           | <input type="checkbox"/> Left Buttock  |
| <input type="checkbox"/> Left Shoulder  | <input type="checkbox"/> Right Buttock |
| <input type="checkbox"/> Right Shoulder | <input type="checkbox"/> Left Leg      |
| <input type="checkbox"/> Left Arm       | <input type="checkbox"/> Right Leg     |
| <input type="checkbox"/> Right Arm      | <input type="checkbox"/> Left Foot     |
| <input type="checkbox"/> Left Hand      | <input type="checkbox"/> Right Foot    |
| <input type="checkbox"/> Right Hand     | <input type="checkbox"/> Other _____   |

14. Are you experiencing any **numbness or tingling**?

- |                                         |                                         |
|-----------------------------------------|-----------------------------------------|
| <input type="checkbox"/> None           | <input type="checkbox"/> Left buttocks  |
| <input type="checkbox"/> Left Shoulder  | <input type="checkbox"/> Right Buttocks |
| <input type="checkbox"/> Right shoulder | <input type="checkbox"/> Left Leg       |
| <input type="checkbox"/> Left Arm       | <input type="checkbox"/> Right Leg      |
| <input type="checkbox"/> Right Arm      | <input type="checkbox"/> Left Foot      |
| <input type="checkbox"/> Left Hand      | <input type="checkbox"/> Right Foot     |
| <input type="checkbox"/> Right Hand     | <input type="checkbox"/> Other _____    |

15. Please rate your pain today on a scale of 0-10 (0= no pain and 10= your worst pain ever)

**0    1    2    3    4    5    6    7    8    9    10**

16. At what time of day are your symptoms **worst**?

- |                                    |                                         |
|------------------------------------|-----------------------------------------|
| <input type="checkbox"/> None      | <input type="checkbox"/> Evening        |
| <input type="checkbox"/> Morning   | <input type="checkbox"/> While Awake    |
| <input type="checkbox"/> Afternoon | <input type="checkbox"/> While Sleeping |

17. At what time of day are your symptoms **best**?

- |                                    |                                         |
|------------------------------------|-----------------------------------------|
| <input type="checkbox"/> None      | <input type="checkbox"/> Evening        |
| <input type="checkbox"/> Morning   | <input type="checkbox"/> While Awake    |
| <input type="checkbox"/> Afternoon | <input type="checkbox"/> While Sleeping |

# Bowlby Chiropractic

---

## *PREVIOUS CARE*

18. Have you seen anyone else for this condition?

- |                                       |                                             |
|---------------------------------------|---------------------------------------------|
| <input type="checkbox"/> No           | <input type="checkbox"/> Physical Therapist |
| <input type="checkbox"/> Chiropractor | <input type="checkbox"/> Specialist _____   |
| <input type="checkbox"/> MD           | <input type="checkbox"/> Other _____        |

19. Name and Location: \_\_\_\_\_

Name and Location: \_\_\_\_\_

20. What happened to your condition as a result of that treatment?

- |                                          |                                                                  |
|------------------------------------------|------------------------------------------------------------------|
| <input type="checkbox"/> Resolved        | <input type="checkbox"/> Improved but not to an Acceptable Level |
| <input type="checkbox"/> Went Unresolved | <input type="checkbox"/> Worsened                                |

21. Who is your Primary Care Physician? \_\_\_\_\_

(Name and location)

## *MEDICAL HISTORY*

22. Please list any allergies: \_\_\_\_\_

23. Do you have a history of any of the following?  Yes  No

- |                                      |                                                 |                                                 |
|--------------------------------------|-------------------------------------------------|-------------------------------------------------|
| <input type="checkbox"/> Work Injury | <input type="checkbox"/> Motor Vehicle Accident | <input type="checkbox"/> Slip and Fall Accident |
|--------------------------------------|-------------------------------------------------|-------------------------------------------------|

24. If so, please list approximate dates and incidents of the injuries

- |                |                 |
|----------------|-----------------|
| 1) Date: _____ | Incident: _____ |
| 2) Date: _____ | Incident: _____ |
| 3) Date: _____ | Incident: _____ |
| 4) Date: _____ | Incident: _____ |

25. Have you ever been hospitalized?  No  Yes If so, when and for what condition?

- |                |                  |
|----------------|------------------|
| 1) Date: _____ | Condition: _____ |
| 2) Date: _____ | Condition: _____ |
| 3) Date: _____ | Condition: _____ |
| 4) Date: _____ | Condition: _____ |

26. Have you had any surgeries?  No  Yes If so, when and for what surgery?

- |                |                 |
|----------------|-----------------|
| 1) Date: _____ | Surgery : _____ |
| 2) Date: _____ | Surgery : _____ |
| 3) Date: _____ | Surgery : _____ |
| 4) Date: _____ | Surgery : _____ |

# REVIEW OF SYSTEMS

Are you currently suffering from any of the problems below?

- General Fatigue
- Weakness Fever (continuous)
- Loss of Sleep
- Chills (continuous)
- Weight change
- Night sweats
  
- Headaches
- Dizziness
- Fainting
- Convulsions
- Nervousness
  
- Anxiety
- Depression (prolonged)
- Phobias (excessive fears)
- Memory loss or impairment
- Mood swings (excessive)
  
- Hearing trouble
- Ringing in ears
- Pain in ears
- Ear discharge
- Vision trouble
- Pain in eyes
- Eye discharge
  
- Nose/sinus pain,
- Excessive drainage
- Nose bleeds (chronic)
- Nasal infections (chronic)
- Absence of smell
  
- Mouth sores,
- Bleeding gums
- Enlarged glands
- Absence of taste
- Abnormal taste sensation
- Tonsillitis/infected tonsils
- Difficulty swallowing
  
- Heat/cold intolerance
- Sugar in urine
- Goiter (enlarged thyroid gland)
- Tremor (shaking)
  
- Skin rash
- Redness of skin
- Skin itching
- Skin dryness
- Eczema (red/inflamed skin)
- Hair changes
- Nail changes
- Bruise easily
  
- Cough (chronic)
- Wheezing (chronic)
- Difficulty breathing
- Swollen extremities
- Blue extremities
- Varicosities (visible veins)
- Rapid heart beat
- Chest pain
- Heart palpitations
- Heart murmur
  
- Decreased appetite
- Increased appetite
- Abdominal pain
- Hemorrhoids
- Excessive gas
- Vomiting (excessive)
- Diarrhea (excessive)
- Constipation (excessive)
- Heartburn/indigestion
  
- Prostate problems
- Painful urination
- Inability to hold urine
- Frequent urination
- Bed-wetting
- Irregular menstruation
- Painful menstruation
- Abnormal vaginal bleeding
- Sterility
  
- Impotence
- Lumps in breast(s)
- Redness/itching of breast
- Dimpling of breast(s)
- Discharge from breast(s)
- Breast pain

Printed Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

**X**

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

(Please sign to certify that the above information is true to the best of your knowledge.)

# Bowlby Chiropractic

---

## *Revised Oswestry Low Back Pain Disability Questionnaire*

Name \_\_\_\_\_

Date \_\_\_\_\_

This questionnaire is designed to enable us to understand how much your low back pain has affected your ability to manage your everyday activities. Please answer **each question** by circling the number that corresponds to the sentence that most applies to you. We realize that you may feel that more than one statement may relate to you, but **please, just circle the one choice which closely describes your problem now.**

### Pain Intensity

- A. The pain comes and goes and is very mild.
- B. The pain is mild and does not vary much.
- C. The pain comes and goes and is moderate.
- D. The pain is moderate and does not vary much.
- E. The pain is severe but comes and goes.
- F. The pain is severe and does not vary much.

### Personal Care

- A. I would not have to change my way of washing or dressing in order to avoid pain.
- B. I do not normally change my way of washing or dressing even though it causes some pain.
- C. Washing and dressing increases the pain, but I manage not to change my way of doing it.
- D. Washing and dressing increases the pain and I find it necessary to change my way of doing it.
- E. Because of the pain, I am unable to do some washing and dressing without help.
- F. Because of the pain, I am unable to do any washing or dressing without help.

### Lifting

- A. I can lift heavy weights without extra pain.
- B. I can lift heavy weights, but it causes extra pain.
- C. Pain prevents me from lifting heavy weights off the floor.
- D. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g., on a table.
- E. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- F. I can only lift very light weights, at the most.

### Walking

- A. Pain does not prevent me from walking any distance.
- B. I have some pain with walking but it does not increase with distance.
- C. Pain prevents me from walking more than one mile.
- D. Pain prevents me from walking more than ½ mile.
- E. I can only walk while using a cane or on crutches.
- F. I am in bed most of the time and have to crawl to the toilet.

(OVER)

# Bowlby Chiropractic

---

## Sitting

- A. I can sit in any chair as long as I like without pain.
- B. I can only sit in my favorite chair as long as I like.
- C. Pain prevents me from sitting more than one hour.
- D. Pain prevents me from sitting more than ½ hour.
- E. Pain prevents me from sitting more than ten minutes.
- F. Pain prevents me from sitting at all.

## Standing

- A. I can stand as long as I want without pain.
- B. I have some pain while standing, but it does not increase with time.
- C. I cannot stand for longer than one hour without increasing pain.
- D. I cannot stand for longer than ½ hour without increasing pain.
- E. I cannot stand for longer than ten minutes without increasing pain.
- F. I avoid standing, because it increases the pain straight away.

## Sleeping

- A. I get no pain in bed.
- B. I get pain in bed, but it does not prevent me from sleeping well.
- C. Because of pain, my normal night's sleep is reduced by less than one-quarter.
- D. Because of pain, my normal night's sleep is reduced by less than one-half.
- E. Because of pain, my normal night's sleep is reduced by less than 3 quarters.
- F. Pain prevents me from sleeping at all.

## Social Life

- A. My social life is normal and gives me no pain.
- B. My social life is normal, but increases the degree of my pain.
- C. Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.
- D. Pain has restricted my social life and I do not go out very often.
- E. Pain has restricted my social life to my home.
- F. Pain prevents me from having a social life.

## Traveling

- A. I get no pain while traveling.
- B. I get some pain while traveling, but none of my usual forms of travel make it any worse.
- C. I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
- D. I get extra pain while traveling which compels me to seek alternative forms of travel.
- E. Pain restricts all forms of travel.
- F. Pain prevents all forms of travel except that done lying down.

## Changing Degree of Pain

- A. My pain is rapidly getting better.
- B. My pain fluctuates, but overall is definitely getting better.
- C. My pain seems to be getting better, but improvement is slow at present.
- D. My pain is neither getting better nor worse.
- E. My pain is gradually worsening.
- F. My pain is rapidly worsening.

# Bowlby Chiropractic

---

## *Neck Pain Disability Index Questionnaire*

Name \_\_\_\_\_

Date \_\_\_\_\_

**Please circle the one choice, which closely describes your problem now.**

This questionnaire is designed to enable us to understand how much your low back pain has affected your ability to manage your everyday activities. Please answer **each question** by circling the number that corresponds to the sentence that most applies to you. We realize that you may feel that more than one statement may relate to you, but **please, just circle the one choice which closely describes your problem now.**

### Pain Intensity

- A. I have no pain at the moment.
- B. The pain is very mild at the moment.
- C. The pain comes and goes and is moderate.
- D. The pain is moderate and does not vary much.
- E. The pain is very severe but comes and goes.
- F. The pain is severe and does not vary much.

### Personal Care

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

### Lifting

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

### Reading

- A. I can read as much as I want to with no pain in my neck.
- B. I can read as much as I want to with slight pain in my neck.
- C. I can read as much as I want with moderate pain in my neck.
- D. I cannot read as much as I want because of moderate pain in my neck.
- E. I cannot read as much as I want because of severe pain in my neck.
- F. I cannot read at all.

(OVER)

# Bowlby Chiropractic

---

## Headaches

- A. I have no headaches at all.
- B. I have slight headaches, which come infrequently.
- C. I have moderate headaches, which come infrequently.
- D. I have moderate headaches, which come frequently.
- E. I have severe headaches, which come frequently.
- F. I have headaches almost all the time.

## Concentration

- A. I can concentrate fully when I want to with no difficulty.
- B. I can concentrate fully when I want to with slight difficulty.
- C. I have a fair degree of difficulty in concentrating when I want to.
- D. I have a lot of difficulty in concentration when I want to.
- E. I have a great deal of difficulty in concentration when I want to.
- F. I cannot concentrate at all.

## Work

- A. I can do as much work as I want to.
- B. I can only do my usual work, but no more.
- C. I can do most of my usual work, but no more.
- D. I cannot do my usual work.
- E. I can hardly do any work at all.
- F. I cannot do any work at all.

## Driving

- A. I can drive my car without any neck pain.
- B. I can drive my car as long as I want with slight pain in my neck.
- C. I can drive my car as long as I want with moderate pain in my neck.
- D. I cannot drive my car as long as I want because of moderate pain in my neck.
- E. I can hardly drive at all because of severe pain in my neck.
- F. I cannot drive my car at all.

## Sleeping

- A. I have no trouble sleeping.
- B. My sleep is slightly disturbed (less than 1 hour sleepless).
- C. My sleep is mildly disturbed (1-2 hours sleepless).
- D. My sleep is moderately disturbed (2-3 hours sleepless).
- E. My sleep is greatly disturbed (3-5 hours sleepless).
- F. My sleep is completely disturbed (5-7 hours sleepless).

## Recreation

- A. I am able to engage in all of my recreational activities, with no neck pain at all.
- B. I am able to engage in all of my recreational activities, with some pain in my neck.
- C. I am able to engage in most, but not all of my usual recreational activities because of pain in my neck.
- D. I am able to engage in a few of my usual recreational activities because of pain in my neck.
- E. I can hardly do any recreational activities because of pain in my neck.
- F. I cannot do any recreational activities at all.