

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]

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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: _____

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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?

- | |
|---|
| <input type="checkbox"/> Yes _____ |
| <input type="checkbox"/> 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 | |

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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 |

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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.)

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Automobile Crash Questionnaire

Date: _____

Name: _____

1. What is the date of the accident? _____

2. In your own words, please describe what happened. _____

3. What was your position in the vehicle at the time of the accident?

- | | |
|--|---|
| <input type="checkbox"/> Driver | <input type="checkbox"/> Left Rear Side Passenger |
| <input type="checkbox"/> Front Side Passenger | <input type="checkbox"/> Right Rear Side Passenger |

4. What type of vehicle were you in? _____

5. How many other People were in the car with you?

- | | |
|---|-----------------------------------|
| <input type="checkbox"/> No one else | |
| <input type="checkbox"/> 1 | <input type="checkbox"/> 4 |
| <input type="checkbox"/> 2 | <input type="checkbox"/> 5 |
| <input type="checkbox"/> 3 | <input type="checkbox"/> 6 |

6. What type of vehicle was the other party driving? _____

7. Were you wearing a seatbelt at the time of impact?

- Yes**
 No

8. What was your vehicle doing at the time of impact?

- Moving**
 Stopped

9. Were you prepared for the impact?

- Yes, I was prepared for the impact.**
 No, I was taken by surprise.

10. How were you impacted?

- | | |
|---|---|
| <input type="checkbox"/> Head On | <input type="checkbox"/> Obliquely from the Front Left Side |
| <input type="checkbox"/> From the Rear | <input type="checkbox"/> Obliquely from the Front Right Side |
| <input type="checkbox"/> From the Left Side | <input type="checkbox"/> Obliquely from the Rear Left Side |
| <input type="checkbox"/> From the Right Side | <input type="checkbox"/> Obliquely from the Rear Right Side |

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11. What was your body position during the impact?
- | | |
|---|--|
| <input type="checkbox"/> Head Straight | <input type="checkbox"/> Torso Straight |
| <input type="checkbox"/> Head Turned Left | <input type="checkbox"/> Torso Turned Left |
| <input type="checkbox"/> Head Turned Right | <input type="checkbox"/> Torso Turned Right |
12. How would you describe the damage to your vehicle?
- | | |
|---|---|
| <input type="checkbox"/> Minimal | <input type="checkbox"/> Totaled |
| <input type="checkbox"/> Moderate | <input type="checkbox"/> Unsure |
| <input type="checkbox"/> Extensive | |
13. Right after the crash, did you feel any of the following? (Check all that apply)
- | | |
|---|--|
| <input type="checkbox"/> Disoriented | <input type="checkbox"/> Mid Back Pain |
| <input type="checkbox"/> Confused | <input type="checkbox"/> Low Back Pain |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Upper Extremity Pain |
| <input type="checkbox"/> Upper back Pain | <input type="checkbox"/> Lower Extremity Pain |
14. Were the police called to the scene?
- Yes**
 No
15. Immediately after the accident, what did you do?
- | | |
|---|--|
| <input type="checkbox"/> Drove Home | <input type="checkbox"/> Was driven to ER |
| <input type="checkbox"/> Drove to Emergency Room | <input type="checkbox"/> Was driven away |
| <input type="checkbox"/> Was driven Home | |
16. When did the symptoms you are experiencing now begin?
- | | |
|---|---|
| <input type="checkbox"/> Immediately | <input type="checkbox"/> The Next Day |
| <input type="checkbox"/> Shortly After | <input type="checkbox"/> A Few Days Later |
| <input type="checkbox"/> A Few Hours Later | <input type="checkbox"/> A Week Later |
| | <input type="checkbox"/> A Couple of Weeks Later |
17. Any bruises or cuts from the accident?
- None**
 Minor
 Significant
18. Did you strike any of the following?
- | | |
|--|--|
| <input type="checkbox"/> Nothing | <input type="checkbox"/> Side Window |
| <input type="checkbox"/> Steering Wheel | <input type="checkbox"/> Back of Front Seat |
| <input type="checkbox"/> Dashboard | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Windshield | _____ |

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19. Have you sought any other medical treatment for your injuries?

- Yes
- No

20. If so, who have you seen?

- | | |
|---|--|
| <input type="checkbox"/> Medical Doctor | <input type="checkbox"/> Physical Therapist |
| <input type="checkbox"/> Chiropractor | <input type="checkbox"/> Acupuncturist |
| <input type="checkbox"/> Massage Therapist | <input type="checkbox"/> Other _____ |

21. Name and Location: _____

22. Name and Location: _____

23. Have you missed work because of this accident?

- Yes** *Please give dates:* _____
- No**

24. Prior to this accident, **did you ever** experience any of these symptoms before?

- | | |
|---|--|
| <input type="checkbox"/> No | <input type="checkbox"/> Mid Back Pain |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Low Back Pain |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Upper Extremity Pain |
| <input type="checkbox"/> Upper Back Pain | <input type="checkbox"/> Lower Extremity Pain |

25. Have you retained an attorney?

- Yes**
 - Name: _____
 - Firm: _____
 - Phone Number: _____
- No**

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

X _____ *Date:* _____

Printed Name: _____

Relationship to Patient: _____

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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)

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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.

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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)

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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.