



# ROWE

CHIROPRACTIC & PHYSICAL THERAPY

# CENTER

## Spine, Sports & Wellness

### New Patients

Name \_\_\_\_\_ Date \_\_\_\_\_ Soc. Sec. No. \_\_\_\_\_ Email \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Phone \_\_\_\_\_ Cell Phone/Pager \_\_\_\_\_ Age \_\_\_\_\_ Birth Date \_\_\_\_\_ Marital Status: M/S/D

#### Employment Information

Occupation \_\_\_\_\_ Student  Full Time  Part Time  
 Employed By \_\_\_\_\_  Full Time  Part Time Business Phone \_\_\_\_\_  
 Spouse Name \_\_\_\_\_ Spouses Employer \_\_\_\_\_ Bus. Phone \_\_\_\_\_

*Health Ins. — (Note: If accident related Auto Insurance/Workers compensation Ins. Co. is listed as Primary)*

Primary Insurance Co. \_\_\_\_\_ Secondary Ins. Co. \_\_\_\_\_  
 Group No. \_\_\_\_\_ Group No. \_\_\_\_\_  
 Policy No. \_\_\_\_\_ Policy No. \_\_\_\_\_  
 Name of Insured \_\_\_\_\_ Name of Insured \_\_\_\_\_  
 Insured Soc Sec. No. \_\_\_\_\_ Insured Soc Sec. No. \_\_\_\_\_  
 Date of Birth of Insured \_\_\_\_\_ Date of Birth of Insured \_\_\_\_\_

#### Chief Complaints

\*\*\* What complaints or condition brings you to see the doctor today? \_\_\_\_\_  
 When did this condition or complaint begin? \_\_\_\_\_  
 Primary Medical Doctor \_\_\_\_\_ Address \_\_\_\_\_  
 Last Visit \_\_\_\_\_ Do you take prescription medications:  Yes  No

#### Emergency Contact

IN CASE OF EMERGENCY, WHO SHOULD BE NOTIFIED

Relationship \_\_\_\_\_ Phone: Home \_\_\_\_\_ Work \_\_\_\_\_

I hereby give permission to the doctor to release any information requested by my insurance company acquired in the course of my examination and treatment. I also give permission to the doctor to obtain any of my previous medical records which he feels necessary to aid in the diagnosis and/or treatment of my condition.

**I hereby authorize and direct my insurance benefits to be paid directly to the doctor. I understand that ultimately I am financially responsible for all services rendered to me. I also give permission to the doctor to file formal grievances with the Maryland Insurance Commissioner when necessary on my behalf, should my insurance company deny or delay payment of all or part of my medical bills.**

I hereby give permission to the doctor to perform such procedures and administer treatment as he may deem medically/chiropractically necessary in the diagnosis and/or treatment of my condition.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Robert A. Rowe, DC, PC  
Rowe Chiropractic and Physical Therapy Center  
Medical History Questionnaire

Name \_\_\_\_\_ DOB \_\_\_\_\_ Male \_\_\_ Female \_\_\_ Date \_\_\_\_\_

What are your current symptoms?

None \_\_\_ or Check the boxes which apply

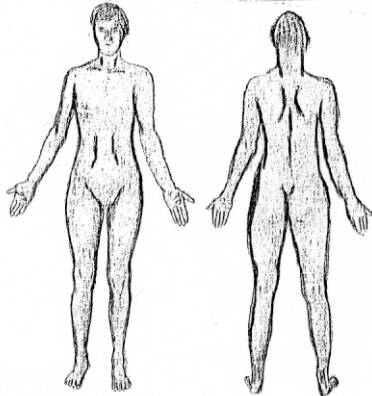
	Pain		Numbness		Tingling	
	L	R	L	R	L	R
Head	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neck	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Upper back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mid back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lower back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	Pain		Numbness		Tingling	
	L	R	L	R	L	R
Shoulder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Forearm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hand	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Buttock	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thigh	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Leg	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Foot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please mark the location of your pain on the figures below:



**Social History**

Does your job require you to sit or stand for long periods of time? Yes \_\_\_ No \_\_\_ Describe: \_\_\_\_\_

Do you have to lift objects repeatedly during the day at work? Yes \_\_\_ No \_\_\_ How much weight? \_\_\_\_\_ lbs

Do you exercise regularly? Yes \_\_\_ No \_\_\_ Cite Type: \_\_\_\_\_

Jog Walk, Jog/Run Aerobics Swim Weights  
other \_\_\_\_\_ Distance \_\_\_\_\_ Time \_\_\_\_\_  
Times/week \_\_\_\_\_

Do you smoke? \_\_\_\_\_ How many packs/day \_\_\_\_\_  
Do you drink coffee? \_\_\_ Alcohol? \_\_\_ Soft Drinks? \_\_\_  
How often? \_\_\_\_\_

When did your current symptoms begin?  
\_\_\_\_\_

Did the onset begin: Gradually over time \_\_\_  
Suddenly \_\_\_

Is this the result of a: Fall \_\_\_ Auto \_\_\_  
Work Injury \_\_\_ Sports Injury \_\_\_  
Other: \_\_\_\_\_

**What makes your pain worse? Check all that apply:**

- Nothing
  - Coughing
  - Sneezing
  - Straining at stool
  - Neck Movement
  - Reaching
  - Lifting
  - Bending
  - Sitting
  - Standing
  - Walking
  - Sleeping
  - Other \_\_\_\_\_
- Have you noticed a change in:
- Bowel function
  - Bladder function
  - Inability to maintain an erection
  - Arm Strength
  - Hand Strength
  - Leg Strength

How bad is your pain level? Circle the number describing your pain level at its worst

0 1 2 3 4 5 6 7 8 9 10  
No pain \_\_\_\_\_ Excruciating \_\_\_\_\_

Have you experienced: Severe or Constant Headache?  
Dizziness Vision Problems Facial Weakness  
Loss of Balance None  
Other \_\_\_\_\_

What SELF treatment have you tried?  
None \_\_\_ Ice \_\_\_ Heat \_\_\_ Exercise \_\_\_

Medications:  
Over the Counter: \_\_\_\_\_  
Prescription: \_\_\_\_\_  
Other \_\_\_\_\_

Have you experienced this condition before? \_\_\_\_\_  
If yes—describe: \_\_\_\_\_

Have you tried chiropractic before? \_\_\_\_\_ If yes, describe:  
\_\_\_\_\_  
With whom? \_\_\_\_\_

# ROWE CHIROPRACTIC AND PHYSICAL THERAPY CENTER

**Review of Systems:** Please check the appropriate box for the symptoms you currently/recently experienced.

**1. General**     None

- Fatigue     Chills     Weakness     Fever     Unexplained weight changes     Night sweats

**2. Neurological**     None

- Headaches     Dizziness     Fainting/loss of consciousness     Convulsions     Tingling     Numbness  
 Loss of Balance     Difficulty Concentrating/Memory loss     Loss of strength     Tremors  
 Drooping eyelid, face, mouth

**3. Eyes, Ears, Nose, Throat**     None

- Loss of vision R L     Blurred Vision R L     Eye/Ear pain R L     Eye/Ear discharge R L  
 Loss of hearing R L     Ringing in ears R L     Nose bleeding     Absence of smell     Sinus infection  
 Mouth/lip sores or bleeding

**4. Cardiovascular and Respiratory**     None

- Persistent cough     Wheezing     Difficulty breathing     Spitting up blood or phlegm     Chest pains  
 Heart murmur     Irregular heart beat/palpitations     Shortness of breath     Swelling in extremities  
 High blood pressure     High cholesterol     Symptoms of Concern: \_\_\_\_\_

**5. Gastrointestinal**     None

- Constipation     Diarrhea     Stomach pain     Vomiting     Loss of appetite     Blood in stools  
 Dark stools     Loss of bowel control     Increased stomach noise/growling  
 Symptoms of concern: \_\_\_\_\_

**6. Genitourinary**     None

- Pain when urinating     Frequent urination     Blood in urine     Kidney stones or infection  
 Bladder infection     Loss of bladder control     Inability to maintain or initiate urine flow     Bed wetting

**7. Endocrine**     None

- High/low blood sugar     Bloating/puffiness of face or body     Excessive sweating  
 Heat/Cold intolerance     Goiter     Tremors/Convulsions     Breast discharge     Other \_\_\_\_\_

**8. Skin**     None

- Rash     Redness/Itching/Eczema     Hair/Nail changes/loss     Moles/growths     Bruising/discoloration

**9. Psychological**     None

- Anxiety     Depression     Confusion     Memory Loss     Mood Swings     Phobias     Other \_\_\_\_\_

**MEDICAL HISTORY: Circle the following conditions you have or had:**

Aids/HIV    Arthritis    Asthma    Allergies    Anemia    Aneurysm    Appendicitis    Arteriosclerosis    Bone fracture  
 Cancer    Chicken Po x    Diabetes    Dislocated Joint    Emphysema    Epilepsy    Fibromyalgia    Foot Problems  
 Gout    Gall Bladder Problems    Heart Disease    High Blood Pressure    Low Blood Pressure    Infection  
 Kidney Problems    Lyme Disease    Liver Problems    Measles    Mumps    Multiple Sclerosis    Mental  
 Illness    Osteoporosis    Pinched Nerve    Polio    Pneumonia    Pacemaker    Prostate Problems    Pregnancy  
 Rheumatic Fever    Scoliosis    Spinal Disc Disease    Stroke    Sexually Transmitted Disease    Tuberculosis  
 Ulcers    Whiplash    Other \_\_\_\_\_

Any Surgeries: \_\_\_\_\_

Any Prescriptions: \_\_\_\_\_

**FAMILY HISTORY Circle the family members which correspond to the condition they have or had:**

**Cancer - Diabetes - Heart Disease - Stroke - High Blood Pressure - Arthritis - Scoliosis - Back/Neck Trouble - Osteoporosis - MS**

Father	Father	Father	Father	Father	Father	Father	Father	Father	Father	Father
Mother	Mother	Mother	Mother	Mother	Mother	Mother	Mother	Mother	Mother	Mother
Brother	Brother	Brother	Brother	Brother	Brother	Brother	Brother	Brother	Brother	Brother
Sister	Sister	Sister	Sister	Sister	Sister	Sister	Sister	Sister	Sister	Sister
Child	Child	Child	Child	Child	Child	Child	Child	Child	Child	Child

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

## REVISED OSWESTRY LOW BACK PAIN QUESTIONNAIRE

PATIENT'S NAME \_\_\_\_\_ Today's Date \_\_\_\_\_

Please circle the ONE answer which **BEST** describes your degree of pain for each category.

### Pain Intensity

0. The pain comes and goes and is very mild
1. The pain is mild does not vary much
2. The pain comes and goes and is moderate
3. The pain is moderate and does not vary much
4. The pain comes and goes and is severe
5. The pain is severe and does not vary much.

### Lifting

0. I can lift heavy weights without extra pain
1. I can lift heavy weights, but it gives me extra pain
2. Pain prevents me from lifting heavy weights off the floor.
3. Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently placed, as on a table.
4. Pain prevents me from lifting heavy weights but I can lift light to medium weights if they are conveniently placed
5. I can only lift very light weights at the most.

### Sitting

0. I can sit in any chair as long as I like without pain.
1. I can only sit in my favorite chair as long as I like.
2. Pain prevents me from sitting more than one hour.
3. Pain prevents me from sitting more than ½ hour.
4. Pain prevents me from sitting more than 10 minutes.
5. Pain prevents me from sitting at all.

### Personal Care (Washing, dressing, etc)

0. I do not have to change my way of washing or dressing in order to avoid pain.
1. I do not normally change my way of washing or dressing even though it causes some pain
2. Washing and dressing increases the pain, but I manage not to change my way of doing it.
3. Washing and dressing increases the pain and I find it necessary to change my way of doing it.
4. Because of the pain I am unable to do some washing and dressing without help.
5. Because of the pain I am unable to do any washing or dressing without help.

### Walking

0. Pain does not prevent me from walking any distance
1. Pain prevents me from walking more than one mile
2. Pain prevents me from walking more than ½ mile
3. Pain prevents me from walking more than 1/4 mile
4. I can only walk while using a cane or crutches
5. I am in bed most of the time and have to crawl to the toilet

### Standing

0. I can stand as long as I want without pain.
1. I have some pain while standing but it does not increase with time
2. I cannot stand for longer than one hour without increasing pain.
3. I cannot stand for longer than ½ hour w/o increasing pain.
4. I cannot stand for longer than 10 minutes w/o increasing pain.
5. I avoid standing because it increases the pain right away.

### Sleeping

0. I get no pain in bed.
1. I get pain in bed but it doesn't keep me from sleeping well.
2. Because of pain my normal nights sleep is reduced by < 1/4.
3. Because of pain my normal nights sleep is reduced by < ½.
4. Because of pain my normal nights sleep is reduced by < 3/4
5. Pain prevents me from sleeping at all.

### Traveling

0. I get no pain when I travel.
1. I get some pain while I travel, but none of my usual forms of travel make it worse.
2. I get extra pain while traveling but it does not compel me to seek alternative forms of travel.
3. I get extra pain while traveling which compels me to seek alternative forms of travel.
4. Pain restricts all forms of travel.
5. Pain prevents all forms of travel except that done lying down.

### Social Life

0. My social life is normal and gives me no pain.
1. My social life is normal but increases the degree of my pain
2. Pain has no significant effect on my social life apart from limiting my more energetic interests eg, dancing, sports etc
3. Pain has restricted my social life; I don't go out very much.
4. I have hardly any social life because of pain
5. I can't drive my car at all because of the pain.

### Changing Degree of Pain

0. My pain is rapidly getting better.
1. My pain fluctuates but overall is definitely getting better.
2. My pain seems to be getting better but improvement is slow at present.
3. My pain is neither getting better or worse.
4. My pain is gradually worsening.
5. My pain is rapidly worsening.

Signature of Patient \_\_\_\_\_

## NECK DISABILITY INDEX QUESTIONNAIRE

PATIENT'S NAME \_\_\_\_\_ Today's Date \_\_\_\_\_

**Please circle the answer which best describes your degree of pain for each category.**

### **Pain Intensity**

0. I have no pain at the moment
1. The pain is very mild at the moment
2. The pain is moderate at the moment
3. The pain is fairly severe at the moment
4. The pain is very severe at the moment
5. The pain is the worst imaginable at the moment

### **Lifting**

0. I can lift heavy weights without extra pain
1. I can lift heavy weights, but it gives me extra pain
2. Pain prevents me from lifting heavy weights off the floor but I can manage if they are conveniently positioned, as on a table.
3. Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently placed.
4. I can lift very light weights.
5. I cannot lift or carry anything at all.

### **Headaches**

0. I have no headaches at all
1. I have slight headaches, which come infrequently
2. I have moderate headaches, which are infrequent
3. I have moderate headaches which come frequently
4. I have severe headaches, which come frequently
5. I have headaches all the time.

### **Personal Care (Washing, dressing, etc)**

0. I can look after myself normally without causing extra pain.
1. I can look after myself normally, but it causes extra pain.
2. It is painful to look after myself and I am slow and careful.
3. I need help every day in most aspects of self care.
4. I need some help every day in most aspects of self care.
5. I do not get dressed, I wash with difficulty and stay in bed

### **Reading**

0. I can read as much as I like with no pain in my neck
1. I can read as much as I want with slight pain in my neck
2. I can read as much as I want with moderate pain in my neck
3. I can't read as much as I want because of moderate pain in my neck
4. I can hardly read at all due to severe pain in my neck
5. I cannot read at all due to severe pain in my neck.

### **Concentration**

0. I can concentrate fully when I want with no difficulty
1. I can concentrate fully when I want w/slight difficulty
2. I have a fair degree of difficulty in concentrating when I want.
3. I have a lot of difficulty in concentrating when I want.
4. I have a great deal of difficulty in concentrating when I want
5. I cannot concentrate at all.

### **Work**

0. I can do as much work as I want.
1. I can only do my usual work, but no more
2. I can do most of my usual work, but no more
3. I cannot do my usual work.
4. I can hardly do any work at all
5. I can't do any work at all.

### **Sleeping**

0. I have no trouble sleeping
1. My sleep is slight disturbed (< 1 hour sleeplessness)
2. My sleep is mildly disturbed (1-2 hrs sleeplessness)
3. My sleep is moderately disturbed (2-3 hrs sleeplessness)
4. My sleep is greatly disturbed (3-5 hrs sleeplessness)
5. My sleep is completely disturbed (5-7 hrs sleeplessness)

### **Driving**

0. I can drive my car w/o pain in my neck
1. I can drive my car as long as I want with slight pain in my neck
2. I can drive my car as long as I want with moderate pain in my neck
3. I can't drive my car as long as I want because of moderate pain in my neck
4. I can hardly drive at all because of severe neck pain
5. I can't drive my car at all.

### **Recreation**

0. I am able to engage in all my recreational activities with no neck pain at all.
1. I am able to engage in all my recreational activities w/some pain in my neck.
2. I am able to engage in most, but not all, of my usual recreational activities due to pain in my neck
3. I am able to engage in just a few of my usual rec. activities because of pain in my neck.
4. I can hardly do any recreational activities due to neck pain.
5. I can't do any recreational activities at all.

Signature of Patient \_\_\_\_\_

**HIPAA NOTICE OF PRIVACY PRACTICES**

*Rowe Chiropractic and Physical Therapy Center*

Protecting the privacy of your health information is important to us. This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Disclosure of protected health information (PHI) without authorization is limited to defined situations including emergency care, quality assurance, public health, research and law enforcement activities. Any other disclosures for the purposes of treatment, payment, or practice operations will be made only after obtaining your consent. You may request restrictions on disclosures and, if we decide to grant your request, we are bound by our agreement.

Disclosures of PHI are limited to the minimum necessary for the purpose of the request. This provision does not apply to the transfer of medical records for treatment. You may inspect and receive copies of you records within 30 days of a request. There may be a reasonable cost-based fee for photocopying, postage and preparation.

You may request a change of record. Our practice has the right to accept or deny your request. We maintain a history of PHI disclosures which are available to you.

**Disclosures used in our office:** You will be required to sign a check- in sheet and we may call you by name in the waiting room We may contact you by phone or mail or leave a message on an answering machine/voice mail/e-mail, or with a person pertaining to appointment reminders, missed appointments, business announcements, birthdays, or about our practice and staff. Patient files/travel cards are used during the day and may be incidently noticed by other patients during the day but are secured when the office is closed. **NO ONE OTHER THAN THE DOCTOR AND STAFF HAVE DIRECT ACCESS TO ANY PATIENT FILES OR TRAVEL CARDS AT ANY TIME.** It will be necessary to release PHI to the payer in order to get paid. It may be necessary for us to obtain previous health information from other sources in order to treat you efficiently.

Our practice is required to abide by this notice. We have the right to change this notice in the future. Any revisions will be prominently displayed in a clearly visible location in our office.

You may file a complaint about privacy violations by contacting our privacy officer: Lauren Rowe, Office Manager, 410-224-2210. **I have read and know that I am entitled to a copy of the Notice of Privacy Practices:**

\_\_\_\_\_  
Signed Patient Date

I grant consent to Rowe Chiropractic and Physical Therapy Center (Provider) to use and disclose my PHI for the purposes of treatment, payment, and health care operations as detailed above. I understand I have the right to revoke this consent in writing, except to the extent you have already used or disclosed such information in reliance upon your consent.

\_\_\_\_\_  
Signed Patient Date

**MEDICARE PATIENTS:** I certify that the information given by me in applying for payment under Title XVIII and/or Title XI of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediary carriers any information needed for this or related Medicare claim.

\_\_\_\_\_  
Signed Patient Date

**Authorization of Additional Disclosures:** The Privacy Rule requires that a Provider limit the use and disclosure of PHI. I authorize this Provider to disclose information related to my care, treatment and/or finances to the following named person(s) and understand that the Privacy provisions are waived accordingly for the named:

\_\_\_\_\_

**CONSENT FOR TREATMENT:** I consent to the rendering of care, including treatment and performance of diagnostic procedures. I understand that I am under the care and supervision of Robert A. Rowe, DC, and it is the responsibility of the staff to carry out the instructions of Dr. Rowe. \_\_\_\_\_