ROWE CHIROPRACTIC & PHYSICAL THERAPY CENTER

Spine, Sports & Wellness
Auto Accident

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_____

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

Auto/Work Insurance Co._____ Health Ins. Co._____

Phone No._____ Group No._____

Claim No._____ Policy No._____

Name of Insured_____ Name of Insured_____

Date of Birth of Insured_____ Date of Birth of Insured_____

If Auto/Work Related Injury:

Authorization No._____ ***Date of Accident_____

Claim Adjustor/Contact_____ Phone_____

***Have you retained an attorney? Yes_____ No_____

Name and Phone of Attorney_____

Chief Complaints

What symptoms bring you here today?_____

Other Doctors

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, D.C.,C.C.S.P.
2629 Riva Road • Suite 110 • Annapolis, Maryland 21401 • **Phone: 410-224-2210** • **Fax: 410-224-4001**
www.rowechiro.com

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

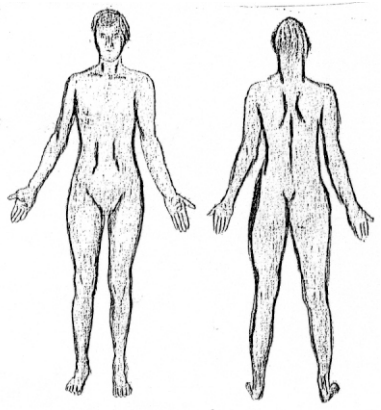
Name _____ DOB_____ Male __ Female __ Date _____

What are your current symptoms?
None ___ or Check the boxes which apply

	Pain L	Pain R	Numbness L	Numbness R	Tingling L	Tingling R
Head	☐	☐	☐	☐	☐	☐
Neck	☐	☐	☐	☐	☐	☐
Upper back	☐	☐	☐	☐	☐	☐
Mid back	☐	☐	☐	☐	☐	☐
Lower back	☐	☐	☐	☐	☐	☐

	Pain L	Pain R	Numbness L	Numbness R	Tingling L	Tingling R
Shoulder	☐	☐	☐	☐	☐	☐
Arm	☐	☐	☐	☐	☐	☐
Forearm	☐	☐	☐	☐	☐	☐
Hand	☐	☐	☐	☐	☐	☐
Buttock	☐	☐	☐	☐	☐	☐
Hip	☐	☐	☐	☐	☐	☐
Thigh	☐	☐	☐	☐	☐	☐
Leg	☐	☐	☐	☐	☐	☐
Foot	☐	☐	☐	☐	☐	☐

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 noice/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 Pox 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
Mother	Mother	Mother	Mother	Mother	Mother	Mother	Mother	Mother	Mother
Brother	Brother	Brother	Brother	Brother	Brother	Brother	Brother	Brother	Brother
Sister	Sister	Sister	Sister	Sister	Sister	Sister	Sister	Sister	Sister
Child	Child	Child	Child	Child	Child	Child	Child	Child	Child

SIGNATURE_____ DATE_____

ROWE CHIROPRACTIC AND PHYSICAL THERAPY CENTER
Robert A. Rowe, DC, PC 2629 Riva Rd, Suite 110, Annapolis, MD 21401 410-224-2210 fax 410 224-4001

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 _____

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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 _____

Auto Accident Questionnaire **Robert A. Rowe, DC**

_____ _____ _____
Name Date of Accident Time

Where did the accident happen? _____

Describe the accident in your own words: _____
_____
_____
_____

Please circle the correct answer:
Following initial impact did your vehicle strike another object? Yes No
Were road conditions: Dry Wet Icy Snowy Other_____
What was your position in the vehicle: Driver Passenger
If a passenger were you seated in: Front Right rear Left rear
Was impact from: Front Left side Right side Rear
At impact were you looking: Straight ahead To the Right To the Left Into the rearview mirror
If the driver, were both hands on steering wheel? Yes No Was your foot on the brake? Yes No
Were you braced for impact? Yes No Were you wearing seatbelts? Yes No
Did you strike anything in the vehicle at impact? Yes No If yes, what part of your body hit what part of the vehicle? _____
How did your body move with impact? Forward Backward Sideways Other_____

Describe how you felt immediately following the accident? _____
Were you knocked unconscious? Yes No In a daze? Yes No Confused? Yes No

Did you go to the hospital? Yes No If yes, name of hospital_____
If yes, how did you get there? Ambulance Private Transportation
When?_____
If ambulance, were you put in a neck collar? Brace? Back board? Splint?
Were you x-rayed at the hospital? Yes No What were you told was wrong with you? _____
_____
Were you admitted into the hospital? Yes No For how long? _____
What treatment was rendered to you? _____
What further treatment if any was recommended on your release? _____
Have you seen any other doctor as a result of this accident? Who?_____

LIST YOUR PRESENT COMPLAINTS: _____
_____

Circle: Is your pain: Constant Comes and goes Sharp Dull Always there but worsens sometimes during the day
Are you experiencing any numbness and/or tingling in your (circle): Arms / Hands / Fingers / Legs / Feet / Toes
Are you experiencing any cramps since the accident in: Legs Arms

Circle: Since the accident are you experiencing: Headaches Dizziness Memory loss Nausea Mood Swings Confusion Buzzing or ringing in ears Visual changes Depression Difficulty sleeping

Patient Name _____

What is your most comfortable position: Sitting Standing Lying on: Back Right side Left side Stomach Other _____
Is this different from before the accident? _____

Is it difficult to move around in bed? _____ Does stretching or twisting worsen the pain? _____
Is your pain worse when rising from a chair or seated position? _____ Is your pain worse with: Coughing Sneezing Straining Does your pain increase with bowel movements? _____ Have you noticed any changes in your bowel or bladder function since the accident? _____

When moving your head or torso does your pain increase? _____ If yes, specify:
Forward Backward Side-to-Side Turning Other_____

Do you feel better or worse when moving around? _____ Do any of the following relieve your pain?
Heat Hot bath/ Shower Ice pack Brace Other_____

Are you currently employed? Yes No Full time Part time
HAVE YOU LOST TIME FROM WORK BECAUSE OF THIS ACCIDENT?
Yes No If yes, give dates of loss _____

WERE YOU EXPERIENCING ANY OF THESE COMPLAINTS PRIOR TO THIS ACCIDENT?
Yes No If yes, explain: _____
_____

HAVE YOU BEEN IN ANY PREVIOUS ACCIDENTS PRIOR TO THIS ACCIDENT?
Yes No If yes, explain _____

Are you currently taking any prescription medications? Yes No Please list:
_____
Over the counter medication? _____

Do you exercise regularly? Yes No If yes, has this schedule been interrupted due to the accident? Yes No
Explain_____

Do you suffer from any other conditions? Yes No Explain _____
_____

Patient Signature _____ Date _____

Doctor Comments:
_____
_____
_____
_____
_____
_____

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: Laura Doucet, 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. _____

Effective date of this Notice: February 9, 2010