ROWE CHIROPRACTIC & PHYSICAL THERAPY CENTER

Spine, Sports & Wellness
Auto Accident

Name _____ Date _____ Email _____

Address _____ City _____ State _____ Zip _____

Phone _____ Age _____ Birth Date _____ Marital Status: M/S/D

Employment Information

Occupation _____ Student ☐ Full Time ☐ Part Time

Employed By _____ ☐ Full Time ☐ Part Time

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 Insurance 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, D.C.,C.C.S.P.
127 Lubrano Dr · Suite L-1 · 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

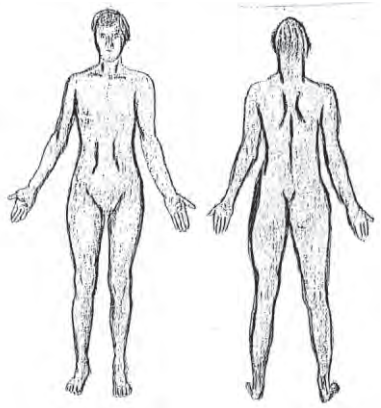
Name _____ DOB_____ Male __ Female __ Date _____

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_____

BACK PAIN QUESTIONNAIRE

Patient Name _____ **Date** _____

This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

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

Sleeping

⓪ I get no pain in bed.
① I get pain in bed but it does not prevent me from sleeping well.
② Because of pain my normal sleep is reduced by less than 25%.
③ Because of pain my normal sleep is reduced by less than 50%.
④ Because of pain my normal sleep is reduced by less than 75%.
⑤ Pain prevents me from sleeping at all.

Sitting

⓪ I can sit in any chair as long as I like.
① I can only sit in my favorite chair as long as I like.
② Pain prevents me from sitting more than 1 hour.
③ Pain prevents me from sitting more than 1/2 hour.
④ Pain prevents me from sitting more than 10 minutes.
⑤ I avoid sitting because it increases pain immediately.

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 1 hour without increasing pain.
③ I cannot stand for longer than 1/2 hour without increasing pain.
④ I cannot stand for longer than 10 minutes without increasing pain.
⑤ I avoid standing because it increases pain immediately.

Walking

⓪ I have no pain while walking.
① I have some pain while walking but it doesn't increase with distance.
② I cannot walk more than 1 mile without increasing pain.
③ I cannot walk more than 1/2 mile without increasing pain.
④ I cannot walk more than 1/4 mile without increasing pain.
⑤ I cannot walk at all without increasing pain.

Personal Care

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 and dressing without help.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor.
③ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
④ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
⑤ I can only lift very light weights.

Traveling

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

Social Life

⓪ My social life is normal and gives me no extra pain.
① My social life is normal but increases the degree of pain.
② Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
③ Pain has restricted my social life and I do not go out very often.
④ Pain has restricted my social life to my home.
⑤ I have hardly any social life 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.
③ My pain is neither getting better or worse.
④ My pain is gradually worsening.
⑤ My pain is rapidly worsening.

NECK PAIN QUESTIONNAIRE

Patient Name _____ ***Date***

This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ I have no pain at the moment.
① The pain is very mild at the moment.
② The pain comes and goes and is moderate.
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.

Sleeping

⓪ I have no trouble sleeping.
① My sleep is slightly disturbed (less than 1 hour sleepless).
② My sleep is mildly disturbed (1-2 hours sleepless).
③ My sleep is moderately disturbed (2-3 hours sleepless).
④ My sleep is greatly disturbed (3-5 hours sleepless).
⑤ My sleep is completely disturbed (5-7 hours sleepless).

Reading

⓪ I can read as much as I want with no neck pain.
① I can read as much as I want with slight neck pain.
② I can read as much as I want with moderate neck pain.
③ I cannot read as much as I want because of moderate neck pain.
④ I can hardly read at all because of severe neck pain.
⑤ I cannot read at all because of neck pain.

Concentration

⓪ I can concentrate fully when I want with no difficulty.
① I can concentrate fully when I want with slight difficulty.
② I have a fair degree of difficulty concentrating when I want.
③ I have a lot of difficulty concentrating when I want.
④ I have a great deal of difficulty 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 only 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 cannot do any work at all.

Personal Care

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 some help but I manage most of my personal care.
④ I need help every day in most aspects of self care.
⑤ I do not get dressed, I wash with difficulty and stay in bed.

Lifting

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

Driving

⓪ I can drive my car without any neck pain.
① I can drive my car as long as I want with slight neck pain.
② I can drive my car as long as I want with moderate neck pain.
③ I cannot drive my car as long as I want because of moderate neck pain.
④ I can hardly drive at all because of severe neck pain.
⑤ I cannot drive my car at all because of neck pain.

Recreation

⓪ I am able to engage in all my recreation activities without neck pain.
① I am able to engage in all my usual recreation activities with some neck pain.
② I am able to engage in most but not all my usual recreation activities because of neck pain.
③ I am only able to engage in a few of my usual recreation activities because of neck pain.
④ I can hardly do any recreation activities because of neck pain.
⑤ I cannot do any recreation activities at all.

Headaches

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

Robert A Rowe DC PC 127 Lubrano Dr Suite L-1 Annapolis MD 21401

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: 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.

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 Signed Patient Date