

Your Life Review –

Bourree Chiropractic

Box 1

Begin Here - Welcome to our Office

If you have enjoyed regular chiropractic wellness care (weekly), please go to box 3.
If this is for pain based care, please go to box 2 and complete the information questionnaire.

Box 2

Current Health Challenge Information

Describe the pain: sharp dull travels constant
Since the onset is the pain: worse better the same on & off
Is there anything that makes it worse: standing sitting lying motion
Are any of your systems involved: digestive cardiovascular respiratory
elimination reproductive
Does the pain cause you to: lose sleep be short tempered miss work
miss play lose focus
Any other facts about your current problem or pain: _____

Box 3 Current Stress index (Holmes-Rahl) circle the ones that pertain to you

death of spouse - divorce - marital separation - jail term - death of close family member - personal injury or illness - marriage - fired from work - marital reconciliations - retirement - family illness - pregnancy - sex difficulties - addition to family - change in business - financial challenge - death of close friend - change in career - increase in marital arguments - loan or mortgage over \$10,000 - foreclosure - change in job responsibilities - child leaving home - trouble with in-laws - outstanding personal achievement - change in spouse's work - starting or finishing school - change in lifestyle - change in personal habits - trouble with boss - change in work conditions - change in residence - change in school - change in recreational habits - change in church activities - change in social activities - loan under \$10,000 change in sleeping habits - change in number of family gatherings - change in eating habits - vacation - Christmas season - minor law violation

Box 4 Please check all your warning signs even if not seemingly related to your complaint.

1 <input type="checkbox"/> frequent colds <input type="checkbox"/> anxiety <input type="checkbox"/> cold hands/feet <input type="checkbox"/> ulcers <input type="checkbox"/> bowel problems <input type="checkbox"/> restless sleep <input type="checkbox"/> nervousness <input type="checkbox"/> high BP <input type="checkbox"/> tight muscles <input type="checkbox"/> accelerated aging <input type="checkbox"/> heart palpitations <input type="checkbox"/> poor expressions of emotions	2 <input type="checkbox"/> ADD <input type="checkbox"/> hypoglycemia <input type="checkbox"/> poor concentration <input type="checkbox"/> cognitive worry <input type="checkbox"/> irritability <input type="checkbox"/> impulsivity <input type="checkbox"/> distraction <input type="checkbox"/> low energy <input type="checkbox"/> disorganization <input type="checkbox"/> incontinence <input type="checkbox"/> muddledness <input type="checkbox"/> poor awakening <input type="checkbox"/> low pain threshold	3 <input type="checkbox"/> headaches <input type="checkbox"/> seizures <input type="checkbox"/> narcolepsy <input type="checkbox"/> PMS <input type="checkbox"/> sleep walking <input type="checkbox"/> hot flashes <input type="checkbox"/> allergies <input type="checkbox"/> bi polar disorders <input type="checkbox"/> eating disorders <input type="checkbox"/> bed wetting <input type="checkbox"/> mood swings <input type="checkbox"/> panic attacks	4 <input type="checkbox"/> fevers <input type="checkbox"/> fatigue <input type="checkbox"/> MS <input type="checkbox"/> Epstein-Barr syndrome <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> depression <input type="checkbox"/> Rheumatoid arthritis <input type="checkbox"/> Chronic fatigue syndrome <input type="checkbox"/> Auto-immune system disorders
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List current medications: _____

Box 5

Injury History

Hospital birth: yes no Play any sports? yes no What sports: _____
Ever broken a bone? _____ Did you: fall as a child yes no Ever been knocked out. yes no
Ever been in any motor vehicle accidents? (please note type and year, even if not apparently injured) _____
Any surgeries? _____

Box 6

Agreements

The statements made on this form are accurate, to the best of my recollection, and I agree to allow this office to do an examination of me for further evaluation.

SIGNATURE _____

DATE _____