

Bourree Chiropractic and Massage
Massage Intake Form

Patient Name: _____ Date: _____

Male Female Other (please select one) Date of Birth: _____ Social security number: _____

Address: _____

Phone number: Home _____ Cell: _____

Email: _____

I authorize Bourree Chiropractic and Massage to leave health related or appointment related voicemails at the number or numbers checked:

Home _____ Cell _____ Preferred Language: _____

Ethnicity (please select): Hispanic Non-Hispanic Unknown (A person who cannot or does not want to declare ethnicity).

Race (please select) : Black White Native American/Eskimo/Aleut Asian/Pacific Islander Other Unknown

Employer: _____ Occupation: _____

Emergency Contact:

Name: _____ Email: _____

Cell: _____ Home: _____

Primary Health Care provider: _____ Phone number: _____

Health History:

Have you received Chiropractic, Massage Therapy, or Therapeutic Cold Laser treatment before? Yes No

What medications are you currently taking? Please include supplements, herbal remedies, and over the counter medications.

(If you have a long list of medications please provide a separate list for our front desk staff).

Please list other medications you have taken over the last 3 months: _____

List all allergies (including food and environmental): _____

Do you smoke? (Please select) Cigarettes- Yes No E-Cigs: Yes No Marijuana: Yes No

Chewing Tobacco- Yes No

Would you like smoking cessation materials? Yes No How many alcoholic beverages do you consume? _____ Day/Week

Please list and explain. Include dates and treatment received if possible:

Surgeries: _____

Accidents: _____ Major Illness: _____

Date of last physical exam: _____ Date of last blood test: _____ Date of last X-Rays: _____

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Family Medical History

Father: Alive? YES NO Current Age: _____ Age of Death if passed: _____ Cause of Death: _____

Father's general health is: Excellent Good Fair Poor

Check those to which the answer is yes (leave others blank)

Heart attacks Strokes High blood pressure Elevated Cholesterol Diabetes Asthma or Hay Fever

Congenital Heart Disease Glaucoma Leukemia Obesity Cancer

Mother: Alive? YES NO Current Age: _____ Age of Death if passed: _____ Cause of Death: _____

Mother's general health is: Excellent Good Fair Poor

Check those to which the answer is yes (leave others blank)

Heart attacks Strokes High blood pressure Elevated Cholesterol Diabetes Asthma or Hay Fever

Congenital Heart Disease Glaucoma Leukemia Obesity Cancer

Siblings: Number of brothers: _____ Number of sisters: _____ Age Range: _____

Health Problems: _____

Additional Family Health problems: _____

Please check All Current and Previous Conditions:

General:

Respiratory and Cardiovascular:

Current Past

- Headaches
- Fatigue
- Sinus
- Sleep disturbances
- Pain
- Infections
- Fever
- Other: _____

Current Past

- Heart Disease
- Poor Circulation
- Shortness of breath
- High/ Low blood pressure
- Asthma
- Irregular heart beat
- Lymphedema
- Chest pain
- Blood clots
- Swollen ankles
- Stroke
- Varicose veins

Skin Conditions:

Current Past

- Rashes
- Athletes foot
- Warts
- Other: _____

Reproductive System:

Current Past

- Pregnancy
- Painful/ emotional menses
- Fibrotic cysts

Endocrine System:

Current Past

- Thyroid dysfunction
- Diabetes

Other: _____

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Muscles and Joints:

- | Current | Past | |
|--------------------------|--------------------------|-----------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Rheumatoid Arthritis |
| <input type="checkbox"/> | <input type="checkbox"/> | Broken bones |
| <input type="checkbox"/> | <input type="checkbox"/> | Lupus |
| <input type="checkbox"/> | <input type="checkbox"/> | Strains/sprains |
| <input type="checkbox"/> | <input type="checkbox"/> | Weak/ sore muscles |
| <input type="checkbox"/> | <input type="checkbox"/> | Scoliosis |
| <input type="checkbox"/> | <input type="checkbox"/> | Spams/ cramps |
| <input type="checkbox"/> | <input type="checkbox"/> | Neck/ shoulder pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Arm pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Low back pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Hip pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Leg pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Osteoarthritis |
| <input type="checkbox"/> | <input type="checkbox"/> | Spinal problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Disc problems |
| <input type="checkbox"/> | <input type="checkbox"/> | TMJ/ jaw pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Tendonitis/ bursitis |
| <input type="checkbox"/> | <input type="checkbox"/> | Stiff/ painful joints |
| <input type="checkbox"/> | <input type="checkbox"/> | Other: _____ |

Digestive/ Elimination System:

- | Current | Past | |
|--------------------------|--------------------------|---------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Bowel dysfunction |
| <input type="checkbox"/> | <input type="checkbox"/> | Bladder dysfunction |
| <input type="checkbox"/> | <input type="checkbox"/> | Gas/ bloating |
| <input type="checkbox"/> | <input type="checkbox"/> | Kidney dysfunction |
| <input type="checkbox"/> | <input type="checkbox"/> | Abdominal pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Other: _____ |

Nervous System:

- | Current | Past | |
|--------------------------|--------------------------|---------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Head injury/ concussion |
| <input type="checkbox"/> | <input type="checkbox"/> | Depression/ anxiety |
| <input type="checkbox"/> | <input type="checkbox"/> | Sciatica/ shooting pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Chronic pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Numbness/ tingling |
| <input type="checkbox"/> | <input type="checkbox"/> | Dizziness/ ear ringing |
| <input type="checkbox"/> | <input type="checkbox"/> | Loss of memory/ confusion |
| <input type="checkbox"/> | <input type="checkbox"/> | Other: _____ |

Cancer or Tumor:

- | Current | Past | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Benign Please let us know where it was located |
| <input type="checkbox"/> | <input type="checkbox"/> | Malignant _____ |

Contract for Care:

I promise to participate fully as a member of my health care team. I will make sound choices regarding my treatment plan based on the information provided by my manual therapist and other members of my health care team, and my experiences of those suggestions. I agree to participate in the self-care program we select. I promise to inform my practitioner any time I feel my well-being is threatened or compromised. I expect my manual therapist or other health care professional to provide safe and effective treatment. Consent for Care It is my choice to receive care, and I give my consent to receive treatment. I have reported all health conditions that I am aware of and will inform my practitioner of any changes in my health.

Printed Name: _____ Date: _____

Signature: _____

Signature of Parent or Guardian: _____ Date: _____

Bourree Chiropractic and Massage

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Massage Therapy Health Report

Name: _____ Date: _____ Date of Injury: _____

Primary Onset (select one): Traumatic Injury Chronic issue Sports injury Car accident Work injury

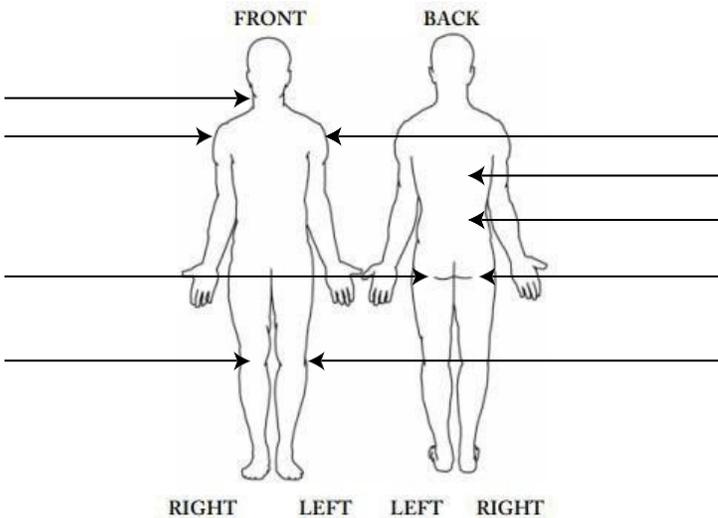
Washington State requires Massage Therapist to have on file the areas in which you are comfortable with them working on. Please circle all the areas of the body it is approved for the Massage Therapist to work on, not just the areas you want to have worked on.:

- | | | | | |
|-------------------------------|--|--|--|-------------------------------|
| <input type="checkbox"/> Head | <input type="checkbox"/> Jaw (Intraoral) | <input type="checkbox"/> Neck | <input type="checkbox"/> Chest (Pectorals) | <input type="checkbox"/> Back |
| <input type="checkbox"/> Arms | <input type="checkbox"/> Abdomen | <input type="checkbox"/> Hips (Gluteal region) | <input type="checkbox"/> Legs | <input type="checkbox"/> Feet |

Please indicate on the diagram where your major symptoms are:

Please mark the body front and back with the appropriate letters from the chart listed below.

- | | |
|--------------------|-----------------------------------|
| P – Pain | E – Effusion (Puffiness or Edema) |
| CP - Constant pain | L – Limitation of movement |
| S – Swelling | W - Weakness |
| T – Tingling | R - Redness |
| N – Numbness | Tg – Tingling |



Identify the Intensity of your symptoms: Select the number on the scale to show the amount of pain or symptoms you're experiencing today.

- | | | | |
|------------|----------------------------------|--|--|
| Neck | <input type="checkbox"/> No Pain | <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 | <input type="checkbox"/> Unbearable pain |
| Upper Back | <input type="checkbox"/> No Pain | <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 | <input type="checkbox"/> Unbearable pain |
| Mid Back | <input type="checkbox"/> No Pain | <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 | <input type="checkbox"/> Unbearable pain |
| Low Back | <input type="checkbox"/> No Pain | <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 | <input type="checkbox"/> Unbearable pain |
| Hips | <input type="checkbox"/> No Pain | <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 | <input type="checkbox"/> Unbearable pain |
| Arms | <input type="checkbox"/> No Pain | <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 | <input type="checkbox"/> Unbearable pain |
| Legs | <input type="checkbox"/> No Pain | <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 | <input type="checkbox"/> Unbearable pain |

Activities Scale: Select the number on the scale to show the limitations you are experiencing today in your daily activities.

- Can do anything I want 1 2 3 4 5 6 7 8 9 10 Cannot do anything

Additional comments: _____

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Functional Rating Index

Primary Complain: _____

Please circle the closest number for pain/ discomfort/ limitation for your current primary complaint.

Pain Intensity

0	1	2	3	4
No pain	Mild pain	Moderate pain	Severe pain	Worst pain possible

Recreation

0	1	2	3	4
Can do all activities	Can do most activities	Can do some activities	Can do few activities	Cannot do any activities

Sleeping

0	1	2	3	4
Perfect sleep	Mild disturbed sleep	Moderate disturbed sleep	Severe disturbed sleep	Totally disturbed sleep

Frequency of pain

0	1	2	3	4
No pain	Occasional pain, 25% of the day	Intermittent pain, 50% of the day	Frequent pain 75% of the day	Constant pain 100% of the day

Personal Care

0	1	2	3	4
No pain no restriction	Mild pain no restriction	Moderate pain, need to go slowly	Moderate pain, need some assistance	Severe pain need 100% assistance

Lifting

0	1	2	3	4
No pain with heavy lifting	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight

Travel

0	1	2	3	4
No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips

Walking

0	1	2	3	4
No pain with any distant	Increased pain after 1 mile	Increased pain after .5 mile	Increased pain after .25 mile	Increased pain with all walking

Work

0	1	2	3	4
Can do usual work plus extra	Can do usual work no extra	Can do 50% of usual work	Can do 25% of usual work	Cannot work

Standing

0	1	2	3	4
No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after 30 minutes	Increased pain with any standing

Name: _____

Date: _____

Score: _____

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Consent for purposes of Treatment, Payment and Health Care Operations

I consent to the use or disclosure of my protected health information by Bourree Chiropractic and Massage for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Bourree Chiropractic and Massage.

I understand that diagnosis or treatment of me by the Massage Therapist may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or health care operations of the practice. Bourree Chiropractic and Massage is not required to agree to the restrictions that I may request. However, if Bourree Chiropractic and Massage agrees to a restriction that I request, the restriction is binding on Bourree Chiropractic and Massage and Dr. David Bourree.

I have the right to revoke this consent in writing at any time except to the extent that Dr. David Bourree or Bourree Chiropractic and Massage has taken action in reliance on this consent.

My "Protected health information" means health information including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present, or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review Bourree Chiropractic and Massage's Notice or Privacy Practices prior to signing this document.

Bourree Chiropractic and Massage's Notice of Privacy has been provided to me.

The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or in the performance of health care operations of Bourree Chiropractic and Massage.

This Notice of Privacy Practices for Dr. David Bourree is also provided at the front desk of Bourree Chiropractic and Massage.

The Notice of Privacy Practices also describes my right and the duties of Dr. David Bourree and staff with respect to my protected health information.

Bourree Chiropractic and Massage reserves the right to change the privacy practices that are described in the Notice of Privacy Practices.

I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Signature of Patient or Personal Representative: _____

Printed name of Patient or Personal Representative: _____

Date: _____ Description of Personal Representatives Authority: _____

With whom may we discuss your healthcare and appointments? _____

Is it okay if we leave a voicemail message for you at the phone numbers provided? (Please select) YES NO

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Massage Therapy Missed Appointment Policy

All appointments are scheduled time with you and your Massage Therapist; when an appointment is missed, someone else could have had that scheduled time with the therapist.

Twenty-Four Hours' advanced notice is required for an appointment cancellation.

If advanced notice is not given, a missed appointment fee of **\$95.00** will be charged directly to you. Insurance companies do not pay for missed appointments, and it must be paid before your next visit to this office.

Please keep your appointments.

I have read and agree to the above.

Initial acknowledgement of cancellation policy: _____

**Insurance Non-covered
Service Disclosure and Agreement**

Type of Service:

Massage Therapy – 97124 \$45.00 for 1 Unit

97140 \$50.00 for 1 Unit

Proposed dates or range of dates of service: See massage therapy care schedule.

Potential Reasons for Non-covered Status:

- The service is or may not be deemed investigational or experimental under the carrier's internal guidelines.
- The service is considered, or may be deemed, not medically necessary under the carrier's internal care or cost management guidelines. *Maintenance care is not covered by insurance.
- The service is not or may not be actually covered under the plan to which the patient is subscribed.
- The service is not or may be deemed as not provided in accordance with the Provider's Agreement with the carrier or other requirements of the carrier's or managed care entity's internal guidelines.

The carrier authorizes the provider to charge the patient for the above services so long as this disclosure is made and signed by the patient prior to the services being provided.

Patient Financial Responsibility:

The undersigned patient acknowledges that the Non-Covered status of the proposed service(s) has been explained, and that a certain portion of the patient's care may not be covered by or has not been authorized by the patient's insurance plan. The undersigned acknowledges that if any portion of the care provided is not, or may not be, covered by insurance, then the undersigned shall be responsible for payment, and shall make the necessary financial arrangements with the healthcare provider to pay for these services.

Printed name: _____

Date: _____

Signature: _____

Insurance plan: _____