Bourree Chiropractic and Massage
New Patient Intake Form

Patient Name:_____ Date: _____

Gender: (please select one) ☐ Male ☐ Female ☐ Other Preferred pronoun:_____ 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:_____ Cell:_____Home:_____

Email: _____

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 cession 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: _____

Bourree Chiropractic and Massage
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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:

Current	Past	
☐	☐	Headaches
☐	☐	Fatigue
☐	☐	Sinus
☐	☐	Sleep disturbances
☐	☐	Pain
☐	☐	Infections
☐	☐	Fever
☐	☐	Other:

Skin Conditions:

Current	Past	
☐	☐	Rashes
☐	☐	Athletes foot
☐	☐	Warts
☐	☐	Other: _____

Endocrine System:

Current	Past	
☐	☐	Rashes
☐	☐	Athletes foot

Respiratory and Cardiovascular:

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

Reproductive System:

Current	Past	
☐	☐	Pregnancy
☐	☐	Painful/ emotional menses
☐	☐	Fibrotic cysts
☐	☐	Other: _____

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Muscles and Joints:

Current	Past	
☐	☐	Rheumatoid Arthritis
☐	☐	Broken bones
☐	☐	Lupus
☐	☐	Strains/sprains
☐	☐	Weak/ sore muscles
☐	☐	Scoliosis
☐	☐	Spams/ cramps
☐	☐	Neck/ shoulder pain
☐	☐	Arm pain
☐	☐	Low back pain
☐	☐	Hip pain
☐	☐	Leg pain
☐	☐	Osteoarthritis
☐	☐	Spinal problems
☐	☐	Disc problems
☐	☐	TMJ/ jaw pain
☐	☐	Tendonitis/ bursitis
☐	☐	Stiff/ painful joints
☐	☐	Other: _____

Digestive/ Elimination System:

Current	Past	
☐	☐	Bowel dysfunction
☐	☐	Bladder dysfunction
☐	☐	Gas/ bloating
☐	☐	Kidney dysfunction
☐	☐	Abdominal pain
☐	☐	Other: _____

Nervous System:

Current	Past	
☐	☐	Head injury/ concussion
☐	☐	Depression/ anxiety
☐	☐	Sciatica/ shooting pain
☐	☐	Chronic pain
☐	☐	Numbness/ tingling
☐	☐	Dizziness/ ear ringing
☐	☐	Loss of memory/ confusion
☐	☐	Other: _____

Cancer or Tumor:

Current	Past		
☐	☐	Benign	Please let us know where it was located
☐	☐	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: _____

Phone: 425-827-0334 Fax: 425-284-6884

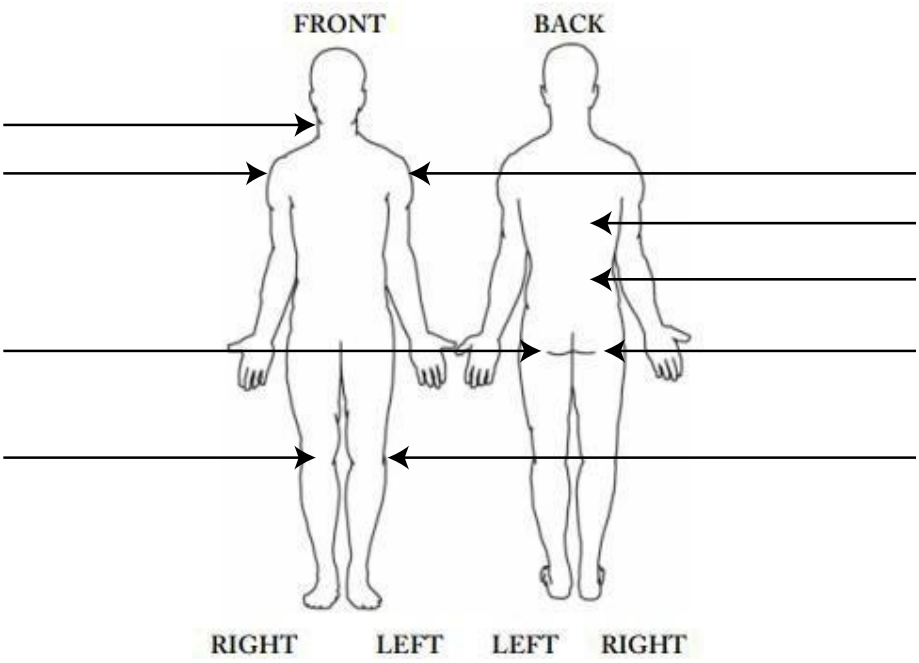
Bourree Chiropractic and Massage
New Patient Intake Form

Patient Evaluation Chart and Questionnaire

Name:_____ Date:_____

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

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.

CP – Constant pain	P – Pain
S – Swelling	T – Tenderness
N – Numbness	Tg – Tingling
R – Redness	E – Effusion (puffiness or edema)
L – Limitation	W - Weakness

How long have you had these symptoms? (Itemize the different body areas if appropriate):

_____

_____

Phone: 425-827-0334 Fax: 425-284-6884

Bourree Chiropractic and Massage
New Patient Intake Form

Symptom List

Please list the concerns that brought you in today:

First Area of complaint: _____

Pain level (please select one): ☐ Mild ☐ Moderate ☐ Severe **Frequency** ☐ Constant ☐ Intermittent

Symptoms (please select one): ☐ Aches ☐ Stabs ☐ Burns ☐ Other: _____

Rate your **symptom** level on a 0-10 scale. (0- no pain 5 moderate pain 10 worst pain possible:

No	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	Worst
Pain	0	1	2	3	4	5	6	7	8	9	10	Possible pain

Second First Area of complaint: _____

Pain level (please select one): ☐ Mild ☐ Moderate ☐ Severe **Frequency** ☐ Constant ☐ Intermittent

Symptoms (please select one): ☐ Aches ☐ Stabs ☐ Burns ☐ Other: _____

Rate your **symptom** level on a 0-10 scale. (0- no pain 5 moderate pain 10 worst pain possible:

No	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	Worst
Pain	0	1	2	3	4	5	6	7	8	9	10	Possible pain

Third First Area of complaint: _____

Pain level (please select one): ☐ Mild ☐ Moderate ☐ Severe **Frequency** ☐ Constant ☐ Intermittent

Symptoms (please select one): ☐ Aches ☐ Stabs ☐ Burns ☐ Other: _____

Rate your **symptom** level on a 0-10 scale. (0- no pain 5 moderate pain 10 worst pain possible:

No	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	Worst
Pain	0	1	2	3	4	5	6	7	8	9	10	Possible pain

Fourth First Area of complaint: _____

Pain level (please select one): ☐ Mild ☐ Moderate ☐ Severe **Frequency** ☐ Constant ☐ Intermittent

Symptoms (please select one): ☐ Aches ☐ Stabs ☐ Burns ☐ Other: _____

Rate your **symptom** level on a 0-10 scale. (0- no pain 5 moderate pain 10 worst pain possible:

No	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	Worst
Pain	0	1	2	3	4	5	6	7	8	9	10	Possible pain

Fifth First Area of complaint: _____

Pain level (please select one): ☐ Mild ☐ Moderate ☐ Severe **Frequency** ☐ Constant ☐ Intermittent

Symptoms (please select one): ☐ Aches ☐ Stabs ☐ Burns ☐ Other: _____

Rate your **symptom** level on a 0-10 scale. (0- no pain 5 moderate pain 10 worst pain possible:

No	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	Worst
Pain	0	1	2	3	4	5	6	7	8	9	10	Possible pain

Bourree Chiropractic and Massage
New Patient Intake Form

Activities of Daily Living Questionnaire

Work:

What type of work do you do? _____

How many hours per day are you able to work now? _____

Prior to Injury? _____

Days per week now? _____

How is your work affected or lost by your injury? _____

_____

_____

_____

Home/Family:

List the activities affected by your injury? _____

_____

_____

Sleep: How many hours per night do you sleep now?_____ Prior to injury? _____

Do you feel rested now?_____ Prior to injury? _____

What affects your sleep? (Examples- pain, not able to go to sleep, not able to wake up etc.)

_____

_____

Social/Recreational:

Activities: _____

_____

_____

Prior to injury? _____

_____

How are your current activities affected? _____

_____

_____

Name:_____ Date:_____

Signature:_____

Phone: 425-827-0334 Fax: 425-284-6884

Bourree Chiropractic and Massage
New Patient Intake Form

Oswestry Neck Pain Disability Questionnaire

PLEASE READ: This questionnaire is designed to enable use to understand how much you **NECK** pain has affected your ability to manage your everyday activities. Please answer each section by circling the ONE CHOICE that most applies to you. We realize that you may feel that more than one statement may relate to you, but PLEASE JUST SELECT THE ONE CHOICE WHICH MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.

Section 1 – Pain Intensity
☐ A – The pain comes and goes and is very mild.
☐ B – The pain is mild and does not vary much.
☐ C – The pain comes and goes and is moderate.
☐ D – The pain is moderate and does not vary much.
☐ E – The pain comes and goes and is severe.
☐ F – The pain is severe and does not vary much.

Section 2 – Personal Care
☐ A – I would not have to change my way of washing or dressing in order to avoid pain
☐ B – I do not normally change my way of washing or dressing even though it causes some pain.
☐ C – Washing and dressing increases the pain, but I manage not to change my way of doing it.
☐ D – Washing and dressing increases the pain and I find it necessary to change my way of doing it.
☐ E – Because of the pain, I am unable to do some washing and dressing without help.
☐ F – Because of the pain, I am unable to do any washing or dressing without help.

Section 3 – Lifting
☐ A – I can lift heavy weights without extra pain.
☐ B – I can lift heavy weights, but it causes extra pain.
☐ C – Pain prevents me from lifting heavy weights off the floor.
☐ D – Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently position, (example on a chair or table).
☐ E – Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently position.
☐ F – I can only lift very light weights, at the most.

Section 4 –Walking
☐ A – Pain does not prevent me from walking any distance.
☐ B – Pain prevents me from walking more than one mile.
☐ C – Pain prevents me from walking more than ½ mile.
☐ D – Pain prevents me from walking more than ¼ mile.
☐ E – I can only walk while using a cane or on crutches.
☐ F – I am in bed most of the time and have to crawl to the toilet.

Section 5 – Sitting
☐ A – I can sit in any chair as long as I like without pain.
☐ B – I can only sit in my favorite chair as long as I like.
☐ C – Pain prevents me from sitting more than one hour.
☐ D – Pain prevents me from sitting more than ½ hour.
☐ E – Pain prevents me from sitting more than 10 minutes.
☐ F – Pain prevents me from sitting at all.

Section 6 – Standing
☐ A – I can stand as long as I want without pain.
☐ B – I have some pain while standing, but it does not increase with time.
☐ C – I cannot stand for longer than one hour without increasing pain.
☐ D – I cannot stand for longer than ½ hour without increasing pain.
☐ E – I cannot stand for longer than 10 minutes without increasing pain.
☐ F – I avoid standing, because it increases the pain straight away.

Bourree Chiropractic and Massage
New Patient Intake Form

Oswestry Neck Pain Disability Questionnaire Continued

Section 7 – Sleeping
☐ A – I get no pain in bed.
☐ B – I get pain in bed, but it does not prevent me from sleeping well.
☐ C – Because of pain, my normal night's sleep is reduced by less than one-quarter.
☐ D – Because of pain, my normal night's sleep is reduced by less than one-half.
☐ E – Because of pain, my normal night's sleep is reduced by less than three-quarters.
☐ F – Pain prevents me from sleeping at all.

Section 8 – Social Life
☐ A – My social life is normal and gives me no pain.
☐ B – My social life is normal, but increases the degree of my pain.
☐ C – Pain has no significant effect on my social life apart from limiting my more energetic activities, (example dancing, ect.)
☐ D – Pain has restricted my social life and I do not go out very often.
☐ E – Pain has restricted my social life to my home.
☐ F – I have hardly any social life because of the pain.

Section 9 – Traveling
☐ A – I get not pain while traveling.
☐ B – I get some pain while traveling, but none of my usual forms of travel make it any worse.
☐ C – I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
☐ D – I get extra pain while traveling which compels me to seek alternative forms of travel.
☐ E – Pain restricts all forms of travel.
☐ F – Pain prevents all forms of travel except that done lying down.

Section 10 – Changing Degree of Pain
☐ A – My pain is rapidly getting better.
☐ B – My pain fluctuates, but overall is definitely getting better.
☐ C – My pain seems to be getting better, but improvement is slow at present.
☐ D – My pain is neither getting better nor worse.
☐ E – My pain is gradually worsening. F – My pain is rapidly worsening.

Additional Comments:

_____

_____

_____

Name:_____ Date:_____ Score:_____

Bourree Chiropractic and Massage
New Patient Intake Form

Oswestry Low Back Pain Disability Questionnaire

PLEASE READ: This questionnaire is designed to enable use to understand how much you **LOWER BACK** pain has affected your ability to manage your everyday activities. Please answer each section by circling the ONE CHOICE that most applies to you. We realize that you may feel that more than one statement may relate to you, but PLEASE JUST SELECT THE ONE CHOICE WHICH MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.

Section 1 – Pain Intensity
☐ A – The pain comes and goes and is very mild.
☐ B – The pain is mild and does not vary much.
☐ C – The pain comes and goes and is moderate.
☐ D – The pain is moderate and does not vary much.
☐ E – The pain comes and goes and is severe.
☐ F – The pain is severe and does not vary much.

Section 2 – Personal Care
☐ A – I would not have to change my way of washing or dressing in order to avoid pain.
☐ B – I do not normally change my way of washing or dressing even though it causes some pain.
☐ C – Washing and dressing increases the pain, but I manage not to change my way of doing it.
☐ D – Washing and dressing increases the pain and I find it necessary to change my way of doing it.
☐ E – Because of the pain, I am unable to do some washing and dressing without help.
☐ F – Because of the pain, I am unable to do any washing or dressing without help.

Section 3 – Lifting
☐ A – I can lift heavy weights without extra pain.
☐ B – I can lift heavy weights, but it causes extra pain.
☐ C – Pain prevents me from lifting heavy weights off the floor.
☐ D – Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently position (example- on a chair or table).
☐ E – Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently position.
☐ F – I can only lift very light weights at the most.

Section 4 –Walking
☐ A – Pain does not prevent me from walking any distance.
☐ B – Pain prevents me from walking more than one mile.
☐ C – Pain prevents me from walking more than ½ mile.
☐ D – Pain prevents me from walking more than ¼ mile.
☐ E – I can only walk while using a cane or on crutches.
☐ F – I am in bed most of the time and have to crawl to the toilet.

Section 5 – Sitting
☐ A – I can sit in any chair as long as I like without pain.
☐ B – I can only sit in my favorite chair as long as I like.
☐ C – Pain prevents me from sitting more than one hour.
☐ D – Pain prevents me from sitting more than ½ hour.
☐ E – Pain prevents me from sitting more than 10 minutes.
☐ F – Pain prevents me from sitting at all.

Section 6 – Standing
☐ A – I can stand as long as I want without pain.
☐ B – I have some pain while standing, but it does not increase with time.
☐ C – I cannot stand for longer than one hour without increasing pain.
☐ D – I cannot stand for longer than ½ hour without increasing pain.
☐ E – I cannot stand for longer than 10 minutes without increasing pain.
☐ F – I avoid standing, because it increases the pain straight away.

Bourree Chiropractic and Massage
New Patient Intake Form

Oswestry Low Back Pain Disability Questionnaire Continued

Section 7 – Sleeping
☐ A – I get no pain in bed.
☐ B – I get pain in bed, but it does not prevent me from sleeping well.
☐ C – Because of pain, my normal night's sleep is reduced by less than one-quarter.
☐ D – Because of pain, my normal night's sleep is reduced by less than one-half.
☐ E – Because of pain, my normal night's sleep is reduced by less than three-quarters.
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Section 8 – Social Life
☐ A – My social life is normal and gives me no pain.
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☐ D – Pain has restricted my social life and I do not go out very often.
☐ E – Pain has restricted my social life to my home.
☐ F – I have hardly any social life because of the pain.

Section 9 – Traveling
☐ A – I get not pain while traveling.
☐ B – I get some pain while traveling, but none of my usual forms of travel make it any worse.
☐ C – I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
☐ D – I get extra pain while traveling which compels me to seek alternative forms of travel.
☐ E – Pain restricts all forms of travel.
☐ F – Pain prevents all forms of travel except that done lying down.

Section 10 – Changing Degree of Pain
☐ A – My pain is rapidly getting better.
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☐ C – My pain seems to be getting better, but improvement is slow at present.
☐ D – My pain is neither getting better nor worse.
☐ E – My pain is gradually worsening. F – My pain is rapidly worsening.

Additional Comments:

_____

_____

_____

Name:_____ Date:_____ Score:_____