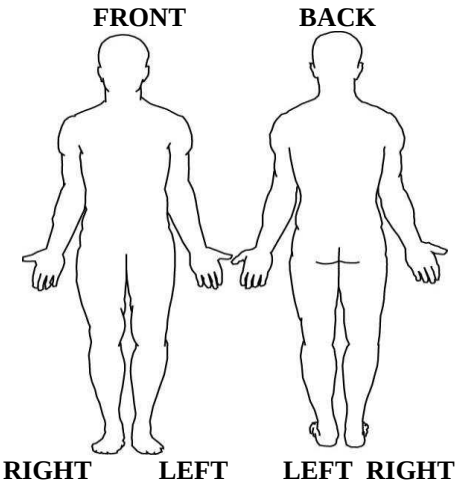
Bourree Chiropractic and Massage
12841 NE 85th Street
Kirkland, WA 98033

Massage Health Report

NAME: _____ DATE: _____ DATE of Injury:_____

Primary Onset (circle one): Traumatic Injury Chronic Issue Sports Injury Car Accident Work Injury

PLEASE INDICATE ON THE DIAGRAM WHRE YOUR MAJOR SYMPTOMS ARE:



Please mark body front and back with the appropriate letters from 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 of Movement**	**W -**	**Weakness**

Identify the Intensity of your Symptoms

1. Pain Scale: Circle the number on the scale to show the amount of pain you are experiencing today.

Upper Back	No Pain	0 1 2 3 4 5 6 7 8 9 10	Unbearable Pain
Mid Back	No Pain	0 1 2 3 4 5 6 7 8 9 10	Unbearable Pain
Low Back	No Pain	0 1 2 3 4 5 6 7 8 9 10	Unbearable Pain

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

Can Do Anything I Want 0 1 2 3 4 5 6 7 8 9 10 Cannot Do Anything

Comments: _____

_____

Signature: _____ Date: _____

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

Bourree Chiropractic and Massage
12841 NE 85th Street
Kirkland, WA 98033

Health Information

A) Patient Information

Patient Name: _____ M/F (circle) SS#_____ Date of Birth: _____
Today's Date: _____
Address: _____ City: _____ State: _____Zip_____
Phone: Home _____ Cell _____ Work _____
Email: _____
I authorize Bourree Chiropractic and Massage to leave health related information at the above (Circle): HOME/CELL/WORK, Phones/Answering machines/Voice mail
Employer: _____ Occupation: _____ Date of Injury: _____
Preferred Language: _____ Ethnicity Select One: ☐Hispanic. ☐Non-Hispanic ☐Unknown (A person who cannot or refuses to declare ethnicity)
Race Select One: ☐White ☐Black ☐Native American/Eskimo/Aleut ☐Asian/Pacific Islander ☐Other ☐Unknown
How Did You Hear About Us_____

Emergency Contact
Name: _____ Home Phone: _____ Cell Phone: _____
Email: _____
Primary Health Care Provider
Name: _____ Address: _____City: _____State: _____ Zip: _____
Phone: _____ Fax: _____ Email: _____

B) Current Health Information

List Health/Concerns. Check all that apply.
Primary_____
☐Mild ☐Moderate ☐Disabling ☐Constant ☐Intermittent
☐Symptoms ↑w/activity ☐Symptoms ↓w/activity ☐Getting Worse ☐Getting Better ☐No Change
Treatment Received_____ Additional _____
Have you ever received Manual/Massage Therapy or Laser Treatment before? ☐YES ☐NO Frequency: _____
List the all medications (including over the counter pain relievers and herbal remedies): _____
_____
List all medications taken in the last 3 months:_____
List all allergies (include environmental and food): _____
Do you Smoke? ☐YES ☐NO, E-Cigs? ☐YES ☐NO, Marijuana? ☐YES ☐NO, Chewing Tobacco? ☐YES ☐NO
If yes, how long have you smoked? _____ How many packs per day/week? _____Have you been offered smoking cession materials? ☐YES ☐NO
If you have not been offered smoking cession materials would you like that information provided at your next visit? ☐YES ☐NO

C) Health History

List and explain. Include dates and treatment received.
Surgeries: _____
Accidents: _____
Major Illness: _____
Date of last physical/annual exam:_____ Date of last Blood Tests: _____ Date of last X-Rays: _____

Bourree Chiropractic and Massage
12841 NE 85th Street
Kirkland, WA 98033

D) Family Medical History

Father: Alive? ☐YES ☐NO Current Age: ____Deceased? ☐YES ☐NO Age of Death: ____ Cause of Death: _____

My 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: ____Deceased? ☐YES ☐NO Age of Death: ____ Cause of Death: _____

My 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 or Comments:_____

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

Bourree Chiropractic and Massage
12841 NE 85th Street
Kirkland, WA 98033

Health Information – Page 2

Please check All Current and Previous Conditions:

General

Current	Past	Comments	Current	Past	Comments
☐	☐	Headaches _____	☐	☐	Pain _____
☐	☐	Fatigue _____	☐	☐	Infections _____
☐	☐	Sinus _____	☐	☐	Fever _____
☐	☐	Sleep Disturbances _____	☐	☐	Other _____

Skin Conditions

Current	Past	Comments	Current	Past	Comments
☐	☐	Rashes _____	☐	☐	Warts _____
☐	☐	Athlete's Foot _____	☐	☐	Other _____

Muscles and Joints

Current	Past	Comments	Current	Past	Comments
☐	☐	Rheumatoid Arthritis	☐	☐	Osteoarthritis
☐	☐	Broken Bones	☐	☐	Spinal Problems
☐	☐	Lupus	☐	☐	TMJ, Jaw Pain
☐	☐	Sprains/Strains	☐	☐	Tendonitis, Bursitis
☐	☐	Weak/Sore Muscles	☐	☐	Neck/Shoulder/Arm Pain
☐	☐	Scoliosis	☐	☐	Disk Problems
☐	☐	Spasms/Cramps	☐	☐	Stiff/Painful Joints
☐	☐	Low Back/Hip/Leg Pain	☐	☐	Other_____

Nervous System

Current	Past	Comments	Current	Past	Current
☐	☐	Head Injury/Concussion	☐	☐	Numbness/Tingling
☐	☐	Depression	☐	☐	Dizziness/Ear Ringing
☐	☐	Sciatica/Shooting Pain	☐	☐	Loss of Memory/Confusion
☐	☐	Chronic Pain	☐	☐	Other_____

Respiratory, Cardiovascular

Current	Past	Comments	Current	Past	Current
☐	☐	Heart Disease	☐	☐	Lymphedema
☐	☐	Poor Circulation	☐	☐	Chest pain
☐	☐	Shortness of Breath	☐	☐	Blood Clots
☐	☐	High/Low Blood Pressure	☐	☐	Swollen Ankles
☐	☐	Asthma	☐	☐	Stroke
☐	☐	Irregular Heartbeat	☐	☐	Varicose Veins

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

Bourree Chiropractic and Massage
12841 NE 85th Street
Kirkland, WA 98033

Health Information – Page 3

Digestive/Elimination System

Current	Past	Comments	Current	Past	Current
☐	☐	Bowl Dysfunction	☐	☐	Abdominal Pain
☐	☐	Gas/Bloating	☐	☐	Bladder Dysfunction
☐	☐	Kidney Dysfunction	☐	☐	Other_____

Endocrine System

Current	Past	Comments	Current	Past	Current
☐	☐	Thyroid Dysfunction	☐	☐	Diabetes

Reproductive System

Current	Past	Comments	Current	Past	Current
☐	☐	Pregnancy	☐	☐	Painful/Emotional Menses
☐	☐	Fibrotic Cysts	☐	☐	Other

Cancer/Tumors

Current	Past	Comments	Current	Past	Current
☐	☐	Benign	☐	☐	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

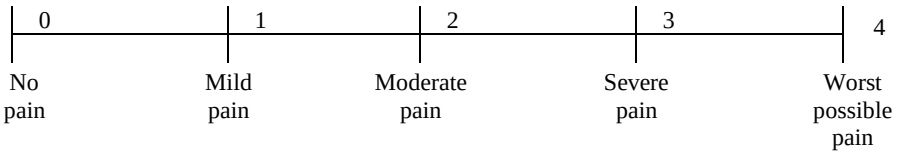
It is my choice to receive care, and I give my consent to receive treatment. I have reported all health conditions that I am aware of and will inform my practitioner of any changes in my health.

Signature: _____ Date: _____

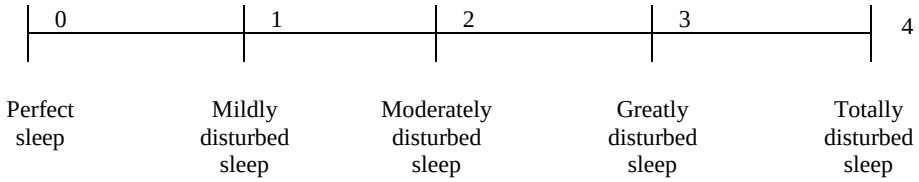
Signature of Parent or Guardian: _____ Date: _____

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

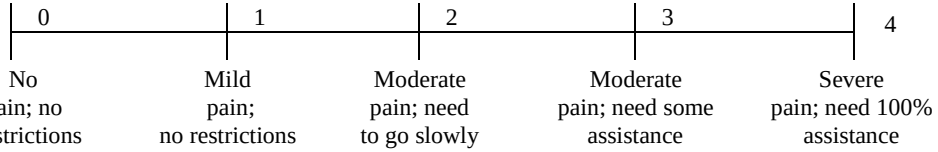
1. Pain Intensity



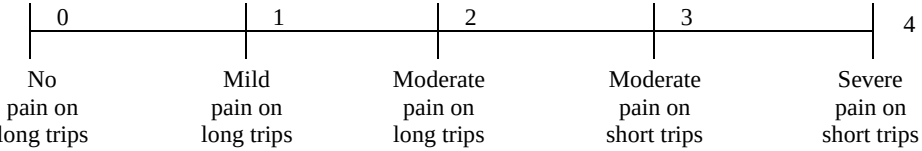
2. Sleeping



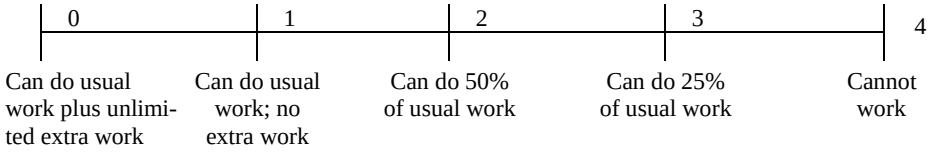
3. Personal Care (Washing, Dressing, Etc.)



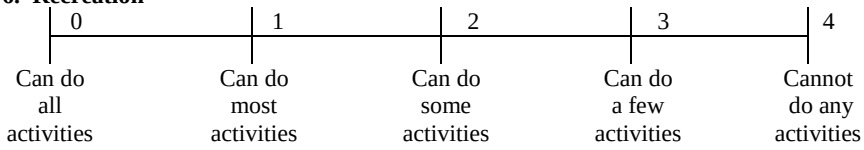
4. Travel (Driving, Etc.)



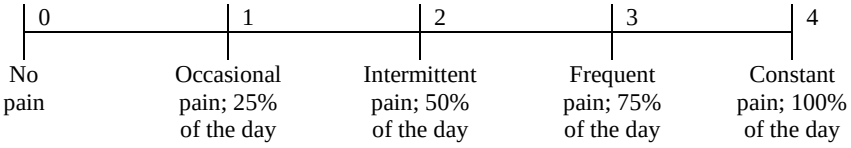
5. Work



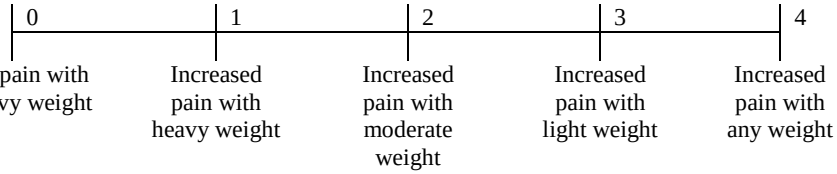
6. Recreation



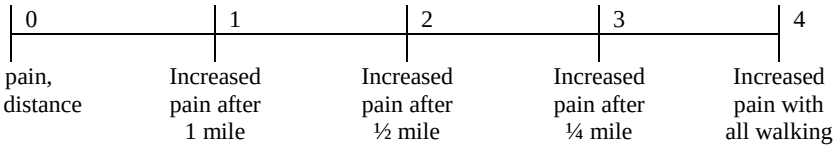
7. Frequency of Pain



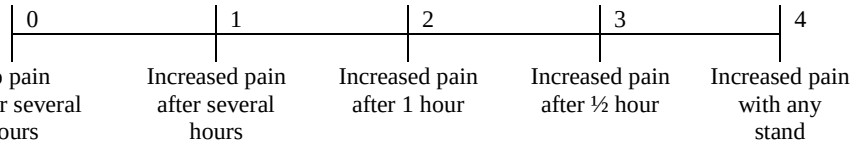
8. Lifting



9. Walking



7. Standing



Printed Name _____ ID#/SS# _____ Plan ID _____ Total Score _____

Signature _____ Date _____

Bourree Chiropractic and Massage
12841 NE 85th Street
Kirkland, WA 98033

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 **Dr. David Bourree** 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 of Privacy Practices prior to signing this document.

Bourree Chiropractic and Massage's Notice of Privacy Practices 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.**

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

This Notice of Privacy Practices also describes my rights and the duties of **Dr. David Bourree** 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

_____
Name of Patient or Personal Representative

_____
Date

_____
Description or Personal Representative's Authority

With whom may we discuss your healthcare and appointments? _____

How may we leave message for you (phone number for voicemail)? _____

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

Bourree Chiropractic and Massage
12841 NE 85th St.
Kirkland, WA 98033

Massage Therapy
Insurance Non-Covered Service Disclosure & Agreement

Name:_____ **Date:**_____

Type of Service:

1. **Massage Therapy:** 97124 $37.50 Per Unit (15 min)
2. **Massage Therapy:** 97140 $37.50 Per Unit (15 min)

Proposed Dates or Range of Dates of Services: See massage therapy care schedule

Potential Reasons for Non-Covered Status:

- The service is or may 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.
- The service is not or may not be actually covered under the plan to which the above 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 as 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, than the undersigned shall be responsible for payment, and shall make the necessary financial arrangements with the healthcare provider to pay for these services.

Print Name: _____

Signature: _____

Date: _____

Insurance Plan: _____

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

Bourree Chiropractic and Massage
12841 NE 85th Street
Kirkland, WA 98033

Massage Therapy Missed Appointment Policy

All appointments are scheduled time with you and your massage therapist; therefore 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 $65.00 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.

Name: _____ **Signature: _____** **Date**: _____

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