Bourree Chiropractic and Massage
Massage Intake Form

Patient Name: ____ Date: ____________

Male/Female/Other (please circle 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 circle): Hispanic Non-Hispanic Unknown (A person who cannot or does not want to declare ethnicity).

Race (please circle): 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 circle) 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: ____________

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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	
____	____	Thyroid dysfunction
____	____	Diabetes

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: ________________

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Massage Therapy Health Report

Name: ____ Date:___________ Date of Injury: ___________

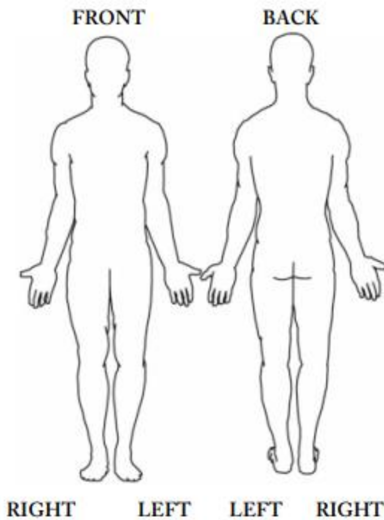
Primary Onset (circle one): Traumatic Injury Chronic issue Sports injury Car accident Work injury

Please check the areas of the body it is approved for the Massage Therapist to work on:

Head ____ Jaw (Intraoral) ____ Neck ____ Chest (Pectorals) ____ Back ____ Arms ____ Abdomen ____ Hips (Gluteal region) ____

Legs ____ Feet____

Please indicate on the diagram where your major symptoms are:



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

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

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

Neck	No Pain	1 2 3 4 5 6 7 8 9 10	Unbearable pain
Upper Back	No Pain	1 2 3 4 5 6 7 8 9 10	Unbearable pain
Mid Back	No Pain	1 2 3 4 5 6 7 8 9 10	Unbearable pain
Low Back	No Pain	1 2 3 4 5 6 7 8 9 10	Unbearable pain
Hips	No Pain	1 2 3 4 5 6 7 8 9 10	Unbearable pain
Arms	No Pain	1 2 3 4 5 6 7 8 9 10	Unbearable pain
Legs	No Pain	1 2 3 4 5 6 7 8 9 10	Unbearable pain

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 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 provided, 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 circle) 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 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: ____