Bourree Chiropractic and Massage
New Patient Intake Form

Patient Name: ____ Date: _____________

Male Female Other (please circle one) 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 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: ________________

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

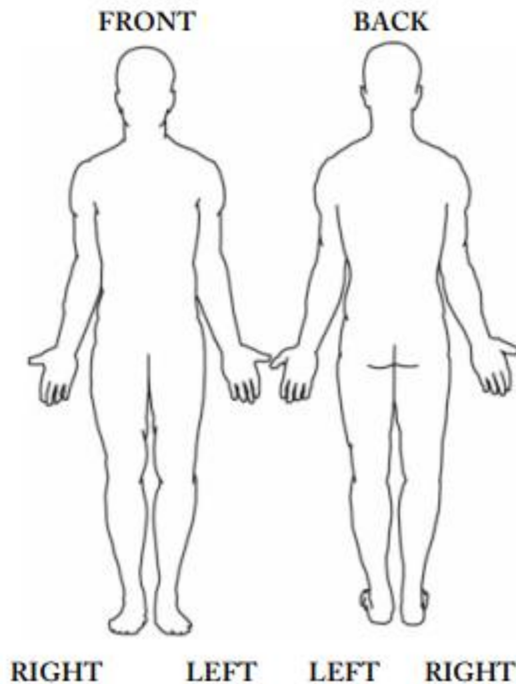
Bourree Chiropractic and Massage
New Patient Intake Form

Patient Evaluation Chart and Questionnaire

Name: ____ Date:__________________

Primary Onset (circle 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):

____

____

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 circle one): Mild Moderate Severe **Frequency:** Constant Intermittent

Symptoms (please circle 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 Pain	0	1	2	3	4	5	6	7	8	9	10	Worst Possible pain

Second Area of complaint: ____________________

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

Symptoms (please circle 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 Pain	0	1	2	3	4	5	6	7	8	9	10	Worst Possible pain

Third Area of complaint: ____________________

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

Symptoms (please circle 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 Pain	0	1	2	3	4	5	6	7	8	9	10	Worst Possible pain

Fourth Area of complaint: ____________________

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

Symptoms (please circle 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 Pain	0	1	2	3	4	5	6	7	8	9	10	Worst Possible pain

Fifth Area of complaint: ____________________

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

Symptoms (please circle 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 Pain	0	1	2	3	4	5	6	7	8	9	10	Worst Possible pain

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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: ____

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 CIRCLE 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.

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 <u>Low Back</u> 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 CIRCLE 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.
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.
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: __________________