HEALTH HISTORY

NAME_____DATE_____
ADDRESS_____
CITY_____STATE_____ZIP_____
PRIMARY PHONE_____SECONDARY PHONE_____
WORK PHONE_____BIRTH DATE_____
EMAIL ADDRESS_____
OCCUPATION_____EMPLOYER_____
ADDRESS_____
SPOUSE _____CHILDREN(Name/Age)_____

_____
WHO REFERRED YOU TO US? _____
PAST CHIROPRACTIC CARE_____
LAST VISIT_____
CURRENT MEDICAL CARE(yes/no)WHY?

_____
CURRENT MEDICATION_____
REASON FOR CONSULTING THIS OFFICE_____
*_____

PLEASE CHECK THE ONE CHOICE THAT MOST CLOSELY DESCRIBES YOUR CURRENT GOALS FOR HEALTH AND WELLNESS.

- I am only concerned about relief of a particular symptom.
- I am only concerned about relief of a particular symptom and preventing its return.
- I want optimum health and wellbeing on every level available to me.

The human body is designed to express health and function normally. However, events may occur in life, which can interfere with this natural ability. This interference is most commonly caused by vertebral subluxations, resulting from physical, chemical or emotional stress. The practice of chiropractic is based on locating and reducing the vertebral subluxation, which causes nerve system interference.

WE ACCEPT PAYMENT BY CASH, CHECK, HSA AND CREDIT CARD
I understand that all services are to be paid in full at the time of service, unless other arrangements have been made and agreed upon in writing.

Signature: _____Date: _____

PLEASE TELL US ABOUT:

STRESS AT YOUR BIRTH:

- Drugs/medicines/tobacco/alcohol in pregnancy?_____
- Labor chemically induced?_____
- Forceps/Vacuum Extraction/C-section_____
- Premature delivery?_____
- Vaccinations?_____
- Falls in 1st year of life?_____
- Any health related problems?_____

STRESS ASSOCIATED WITH CHILDHOOD:

- Falls or injuries?_____
- Allergy/Asthma/Respiratory problems?_____
- Ear infections?_____
- Digestive problems?_____
- Hyperactivity?_____
- Other?_____

STRESS UP TO PRESENT:

- Auto accident?_____
- Work injury?_____
- Work stress?_____
- Sports injury?_____
- Family/home stress?_____
- Prescription drug use?_____
- Non-prescription drug use?_____
- Hospitalizations?_____
- Surgeries?_____
- Major illness?_____
- Reoccurring illness?_____
- Exercise regimen?_____
- Eating habits?_____
- Other?_____

Our Purpose

The Spinal cord carries every message form the brain to the body and from the body to the brain,

If these messages are interfered with...

- You would not be fully able to hear, see, speak or smell
- Your heart could not beat properly.
- Your lungs could not breath fully.
- Your body could not heal well.
- Your immune system could not function as it should.
- You could not fully express **LIFE**!

Therefore, our primary purpose is to educate everyone we can about chiropractic care.

The mission of Boucher Family Chiropractic is to create health and wellness through the expression of the divine within. This is achieved by empowering our community through education of the chiropractic principles and the miracle of the chiropractic adjustment.

Terms of Acceptance

Boucher Family Chiropractic (BFC) agrees to:

- Provide our highest level of attention, skill and support at all times.
- Communicate any information or recommendations that we believe may be helpful to you and your overall health care, self-care or in your understanding of the care you are receiving at BFC.
- Provide regular opportunities for education/personal development relative to your health & well-being.
- Provide you with timely information about your schedule of care, cost and payment arrangements. While BFC does not accept third party (insurance) payment, we will gladly provide you with the documentation you may need to submit to your insurer to receive direct reimbursement.
- Act with integrity and respect in all of our dealings, including timeliness of appointments and communicating concerns as soon as we become aware of them.

You Agree to:

- Take full responsibility for your own health care and well-being.
- While you may have come to BFC with the expectation of relief of a particular symptom or condition, it has been clearly explained to you that the only purpose of chiropractic care is to remove or reduce nerve interference cause by the presence of a vertebral subluxation, in order to promote optimal health. You understand that there is no promise to treat any symptom, condition or disease, and no guarantee of specific results.
- Communicate questions and concerns, as well as any information that may be useful to our support of your optimal health, including other health or alternative care practices, medications, health concerns, mental health issues and/or significant life changes.
- Attend New Beginning talks near the beginning of your initial care. We ask you that you bring your spouse, significant other or close friend with you.
- Make every effort to make up any missed appointments within one week.
- Act with integrity in all of our dealings, including being on time for appointments, providing ample notice when you must cancel or reschedule an appointment, maintaining your recommended schedule of care, completing payment on the agreed schedule and communicating your needs, questions and concerns as soon as you become aware of them.

By my signature below, I indicate my agreement with my Recommended Schedule of care and these Terms of Agreement.

Signature:_____ **Date:**_____

Witness:_____ **Date:**_____

Name_____ Date:_____

Your Current Health Status

Physical State: Rate the following questions on frequency scale of 1 to 5.
1 = never, 2 = rarely, 3 = occasional, 4= regularly, 5 = constantly.

1.	Presence of pain (neck/back ache, sore arms/legs, ect).	1	2	3	4	5
2.	Feeling of stiffness, or lack of flexibility in your spine.	1	2	3	4	5
3.	Incidence of fatigue of low energy.	1	2	3	4	5
4.	Incidence of headaches (any kind).	1	2	3	4	5
5.	Incidence of nausea or constipation.	1	2	3	4	5
6.	Incidence of menstrual discomfort.	1	2	3	4	5
7.	Incidence of allergies or eczema or skin rash.	1	2	3	4	5
8.	Incidence of dizziness or lightheadedness.	1	2	3	4	5

Mental/Emotional State: Rate the following questions on a frequency scale of 1 to 5.
1 = never, 2 = rarely, 3 = occasional, 4= regularly, 5 = constantly.

1.	If pain is present, how stressed are you about it ?	1	2	3	4	5
2.	Presence of negative or critical feelings about yourself.	1	2	3	4	5
3.	Experience of moodiness or temper or angry outbursts.	1	2	3	4	5
4.	Experience of depression or lack of interest.	1	2	3	4	5
5.	Experience of vague fears and anxiety.	1	2	3	4	5
6.	Being fidgety or restful;difficulty concentrating.	1	2	3	4	5
7.	Difficulty falling or staying asleep.	1	2	3	4	5

Stress Evaluation: Evaluate your stress relative to the following on a scale 1 to 5.
1 = none, 2 = slight, 3 = moderate, 4 = pronounced, 5 = extensive.

1.	Family	1	2	3	4	5
2.	Significant Relationship	1	2	3	4	5
3.	Health	1	2	3	4	5
4.	Work/School	1	2	3	4	5
5.	General Well-being	1	2	3	4	5

Life Enjoyment: Rate the following questions on a degree scale of 1 to 5.
1 = not at all, 2 = slight, 3 = moderate, 4 = considerable, 5 = extensive.

1.	Interest in maintaining a healthy lifestyle (e.g.; diet, fitness. etc.)	1	2	3	4	5
2.	Satisfaction with the level of recreation in your life.	1	2	3	4	5
3.	Time devoted to things you enjoy.	1	2	3	4	5
4.	Incidence of feelings of joy and happiness.	1	2	3	4	5