RISE
REORGANIZATIONAL HEALING

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Pediatric Comprehensive Health Profile

Date: _____

Last Name: _____ **First Name**: _____ **Date of Birth**: _____

Street Address: _____

City/State/Zip: _____ **Email**: _____

Mobile Phone: _____ **Work Phone**: _____ **Home Phone**: _____

For Appointment Reminders, I prefer to be contacted via: ❒ Text Message ❒ Email ❒ Phone Call

School: _____ **Grade**: _____

Family Status: ❒ Married ❒ Widowed ❒ Separated Co-Parenting ❒ Single Parent

Adults in Role of Caregiver: _____

_____

How did you discover our office and the professional services we offer?

_____

Please complete this general health history and wellness survey. It will provide your practitioner with important information to better understand your child's history and long term needs, as well as any health related or quality of life compromise you may now be experiencing.

Part I: Your Child's Health Concern or Symptoms and How They May Influence Your Family's Life

1. Does your child have a current health/life situation, condition or concern? If so, please describe: _____
   _____
   _____
2. When did this situation or concern begin? _____
3. Have you done anything about this situation or concern or been given any advice or treatment for it? ❒Yes ❒No
   a) What was done? _____
   b) Did it seem to work? _____
   c) What was different about you after treatment? _____
   _____
   d) What was different about your condition or symptom after treatment? _____
   e) Have your concerns changed since treatment? _____
   _____
4. Please *circle* the level to which this health concern affects these aspects of your child's functioning/quality of life:

Work	0	1	2	3	Eating	0	1	2	3
Social Life	0	1	2	3	Rest/Sleep	0	1	2	3
Exercise	0	1	2	3	Sitting	0	1	2	3
Recreation/Play	0	1	2	3	Love Life	0	1	2	3
Walking	0	1	2	3	Concern About Health	0	1	2	3

0 – Does not affect 1 – Slightly affects 2 –Moderately affects 3 – Drastically affects

Please *circle* the level to which this health concern affects these aspects of your family's functioning/quality of life:

0 1 2 3

5. Have any other family members had the same or similar concerns? ❒ Yes ❒ No

6. Is there any activity during which you or your child *forget* about this condition, symptom, or concern?
_____
7. Is there any time of day where this concern is more/less noticeable? _____
8. Why do you think this has happened or continues to happen to your child ? _____
_____
    a) Do you think this is the sole cause? ❒Yes ❒No
    b) If no, what else is involved? _____
    _____
9. If this condition or symptom were to go away tomorrow, what would be different about your child's life? _____
_____
10. Are you doing anything differently because of this condition/symptom/concern? _____
_____
11. Since the development of this condition/symptom/concern has your child:
    a) Changed any habits? _____
    b) Held or touched part of his/her body more often or differently? _____
    c) Moaned, cried or made sounds that he/she usually do not make? _____
12. In your assessment, which best describes your child's current feeling about his/herself and the situation?

Please Circle

    a) I feel helpless, like little or nothing works.
    b) This is terrible; really bad. I am scared and hope you can fix it for me.
    c) I feel stuck and can't help myself right now.
    d) I deserve more than what I have been experiencing and would like you to assist me in my healing.
    e) Anything else? _____
13. Please *circle* your impression for the following questions:

Currently, how inconvenient is this problem?	**Not at all**	**Slight**	**Moderate**	**Extreme**
How inconvenient was it in the past?	**Not at all**	**Slight**	**Moderate**	**Extreme**

Part II: Health/Trauma/Medical/Chiropractic & Healing History

1. Have your child ever injured his/her spine (neck, head, back, hips)? ❒ Yes ❒ No
    a) Date of most significant injury: _____
    b) What happened? _____
    c) Date of most recent injury: _____
    d) What happened? _____
2. Please list medications (prescription or non-prescription) your child has taken within the past 60 days:
_____
_____
3. In the past, has your child taken other medications for a period of more than three consecutive months? ❒Yes ❒No
    a) What did your child take? _____
    b) What was the reason for taking this medication? _____
4. Has your child had any spinal x-rays, CT scans, or MRI imaging of your spine, head, neck or back? ❒ Yes ❒No
    a) If yes, when? _____
    b) What were you told about them? _____
5. Has your child had any surgeries? ❒Yes❒ No Please explain: _____
_____
6. Has your child broken any bones or significantly sprained any part of your body? ❒ Yes ❒ No Please explain:
_____
7. Please list any herbs, nutritional supplements, or natural remedies your child takes regularly: _____
_____
8. Has your child's spine ever been professionally adjusted/manipulated/entrained? ❒ Yes ❒ No
    a) By whom and when? _____
    b) Why did you go? _____
    c) What did he/she do for your child? _____
    d) Were you pleased? ❒Yes ❒No Are you still going? ❒Yes ❒No
    e) Have you received Network Spinal Analysis Care? ❒Yes ❒No Has your family? ❒Yes ❒No

9. Do you consult with a medical doctor/physician for any other reason than routine evaluations? ❒Yes ❒ No
   a) What is/was the reason for the visit(s)? _____
   b) When was your last visit? _____
   c) What was done or suggested? _____
10. Do you have an exercise, meditation, prayer, nutritional, or dietary program?❒Yes ❒No Please describe:
    _____
11. When stressed, how do you and your child "center yourself" or "regroup"? _____
    _____

Part III: Your Specific Needs and Hopes For Help In This Office

In a published study of over 2,800 patients in Network Care, conducted within the Medical College at the University of California-Irvine, patients reported an overall improvement in all of the categories of health and wellness listed below.

In question 1 and 2, rate the five choices using this scale:

0 – Does not apply 0 – Not so important to me 2 – Important to me 3 – Very important to me

1. How do you hope to benefit from care in the office?

Please Circle

Improvement of my physical symptoms	0	1	2	3
Improvement of emotional/mental symptoms	0	1	2	3
More efficient ability to react or respond to stress	0	1	2	3
Noticeable difference in enjoyment of life	0	1	2	3
Increased ability to make constructive choices	0	1	2	3
Overall improved quality of life	0	1	2	3

2. For a slightly *longer term goal*, how do you hope to benefit from care in the office?

Please Circle

Improvement of my physical symptoms	0	1	2	3
Improvement of emotional/mental symptoms	0	1	2	3
More efficient ability to react or respond to stress	0	1	2	3
Noticeable difference in enjoyment of life	0	1	2	3
Increased ability to make constructive choices	0	1	2	3
Overall improved quality of life	0	1	2	3

3. In your perspective, is there some aspect of your child's life that very much pleases you, brings you joy, or Helps you to feel better about yourself? _____
4. Are there any particular factors or elements about your life experiences, family, work, recreation, past injuries, genetics, dietary programs, exercises, outlook, etc. that you feel impair your child's opportunity for full glowing health? _____
   _____
5. Are there any particular factors or elements that you feel give your child an edge or add to his/her health?
   _____
   _____

Your answers to the following questions will help us better support you and your child in a program of care specifically Focused on your spine, your nervous system, and your health and wellness.

1. When communicating to you about your spine, nervous system, health and wellness:

Please Check

❒ Mostly speak with me about the clinical findings. I want to *hear* about the changes my child and I are making.
❒ Mostly show me in written form the clinical findings. Let me *see* the changes my child and I are making.
❒ Mostly let me get a sense of the clinical work. Help me to *feel* the difference in my body.

2. Is there anything else which may help us to better understand you or your child that have not been addressed on this survey? Please explain: _____
   _____