



Comprehensive Health Profile

Date: _____

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

Street Address: _____

City/State/Zip: _____ Email: _____

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

Why are you here?

- Please fix me up Fix me up and address the underlying causes of my symptoms
- Help me wildly transform my body and life

Occupation: _____ Number of Years: _____

Marital Status: Married Partnered Widowed Divorced Single

Names & Ages of Children: _____

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 history and long term needs, as well as any health related or quality of life compromise you may now be experiencing.

Part I: Your Health Concern or Symptoms and How They May Influence Your Life

1. Do you 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 functioning/quality of life:

Work	0	1	2	3
Social Life	0	1	2	3
Exercise	0	1	2	3
Recreation/Play	0	1	2	3
Walking	0	1	2	3

Eating	0	1	2	3
Rest/Sleep	0	1	2	3
Sitting	0	1	2	3
Love Life	0	1	2	3
Concern About Health	0	1	2	3

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

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

6. Is there any activity during which you totally or almost totally *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 you? _____
- 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 life? _____
10. Are you doing anything differently because of this condition/symptom/concern? _____
11. Since the development of this condition/symptom/concern have you:
- a) Changed any habits? _____
- b) Held or touched part of your body more often or differently? _____
- c) Moaned, cried or made sounds that you usually do not make? _____
12. Which best describes your current feeling about yourself and your situation?
- 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:

**Please
Circle**

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 you ever injured your 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) you have taken within the past 60 days: _____
3. In the past, have you taken other medications for a period of more than three consecutive months? Yes No
- a) What did you take? _____
- b) What was the reason for taking this medication? _____
4. Have you had any spinal x-rays, CT scans, or MRI imaging of your spine, head, neck, back, or hips? Yes No
- a) If yes, when? _____
- b) What were you told about them? _____
5. Have you had any surgeries? Yes No Please explain: _____
6. Have you 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 you take regularly: _____
8. Has your 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 you? _____
- 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 “center yourself” or “regroup”? _____

Have you had experience with the following health treatments or healing modalities?

<u>Modality</u>	<u>When?</u>	<u>For how long?</u>	<u>What were the results</u>
Physiotherapy/ Occupational Therapy			
Osteopathy			
Nutritional Therapy/ Counseling			
Homeopathy/ Herbalist			
Emotional Therapy/ Psychotherapy			
Massage/Bodywork			
Oriental Medicine/ Acupuncture			
Ayurvedic Medicine			
Oxygen Therapy/ Chelation Therapy			
Yoga/Movement/ Tai Chi/Chi Gong			
Music/Dance/Sound/ Light/Aromatherapy			
Rebirthing/Breathwork			
Other: _____			

Part III: Stress Survey

Please grade the following stresses in order of increasing intensity.

0– No awareness of stress 1– Slightly stressful situation 2– Moderately stressful situation 3– Extremely stressful

<i>Please Circle</i>	Overall Physical Stress/Trauma – Includes: falls, accidents, injuries, repeated postural stress, impacts, difficult birth, traction, physical abuse.	0	1	2	3
	Overall Emotional/Mental Stress – Includes: loss of loved ones, rapid change of life situation, mental, emotional, sexual abuse, legal concerns, financial concerns, move of home/school, separation/divorce etc. in relationship, stress of being ill, etc.	0	1	2	3
	Overall Chemical Stress – Includes: drugs, smoke, fumes, food additives	0	1	2	3

Comments: _____

Have you had a work/car accident related injury? Yes No Please describe: _____

Part IV: 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 1 – 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. Is there some aspect of your 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 opportunity for full glowing health? _____

5. Are there any particular factors or elements that you feel give you an edge or add to your health? _____

Your answers to the following questions will help us better support you 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 I am making.
 - Mostly show me in written form the clinical findings. Let me *see* the changes I am 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, your history, or your professional needs, that have not been addressed on this survey? Please explain: _____

***Please double check that the above information is thorough and accurate.
Thank you for choosing our office, we look forward to assisting you.***