Comprehensive Health Profile

Date:_____

Last Name:_____

First name: _____

Address:_____

City:_____

State:_____Zip:_____

Home Phone:_____

Cell Phone:_____

Date of Birth:_____

email:_____

Occupation:_____

How did you discover our
office?:_____

Please complete this general health history. It will provide your practitioner with important information that will enable her to better understand your history and long-term needs as well as any health-related quality of life issues you may be experiencing.

Part I: Your health concerns and symptoms and how they may influence your life.

1. Do you have a current health/life situation or concern? If so, please describe it._____
   _____
   _____
   _____
   _____
   _____
   _____

2. When did this concern begin?_____
3. Have you done anything about this concern or been given any treatment or advice for it?_____
   If yes, what was suggested?_____
4. What was done?_____
5. Did it seem to work?_____
6. What was different after your treatment?_____
7. What was different about your concern after the treatment?_____
8. Have your concerns changed since treatment?_____
9. Please rate the level this health concern effects these areas of your functioning/quality of life

0- It does not effect me 1- Slightly 2- moderately 3- Quite a bit

Work 0 1 2 3 Recreation 0 1 2 3 Rest/Sleep 0 1 2 3 Social life 0 1 2 3
Walking 0 1 2 3 Sitting 0 1 2 3 Exercise 0 1 2 3 Eating 0 1 2 3
Love life 01 2 3 Concern about symptom 0 1 2 3 Concern over health 0 1 2 3

10. Have any other family members had the same or similar concerns_____
11. What did they do about them?
    _____
12. How aware of this concern are you during the day? 0 1 2 3 the night? 0 1 2 3
13. Is there any activity during which you totally or almost totally forget about this concern?_____
14. Is there any time during the day during which you are more or less aware of this concern?_____
15. Why do you think this had happened or continues to happen?_____
    _____
16. Do you think this is the sole cause? Yes No
17. If no, what else is involved?_____
    _____
18. If this condition or symptom were to go away tomorrow, what would be different about your life?_____
19. Are you doing anything differently because of this concern?_____
    _____
20. Since the development of this concern
    1. Have you changed any habits?_____
       _____
    2. Held or touched your body more often or differently?_____

_____

3. Moaned, cried or made sounds that you usually do not make?_____
_____

21. Which best describes your current feelings about yourself and your concern?
    1. I feel helpless, like little or nothing works
    2. this is terrible, really bad and I am scared and hope that you can help me
    3. I feel stuck and can't help myself right now
    4. I deserve more than what I have been experiencing and would like you to assist me in my healing.
    5. Anything else?_____
    _____
    ____
22. Please grade on a scale of *0- not at all 1-Slight 2-Moderate 3 -Extreme*
    1. How inconvenient is your concern? 0 1 2 3
    2. How inconvenient was it in the past? 0 1 2 3

Part II: Health/Trauma/Medical/Chiropractic and Healing history

1. Have you ever injured your spine? (Head, Neck, back, hips)
   a. Date of most significant injury_____
   b. What happened?
   _____

c. Date of most recent injury_____
d. What happened?_____

2. Please list medications (prescription or over the counter) taken in the past 30 days_____
   _____
   _____

3. In the past, have you taken other medications for a period of more than 3 consecutive months?
   1. What did you take _____
   2. What was the reason for taking this medication?_____
4. Have you had any spinal X-rays, CT or MRIs of your spine, head, neck, back or hips?
   1. When?_____
   2. What were you told?_____
   ____
   3. Do you have them?_____
5. Have you had any surgeries?_____
   _____

_____

6. Have you broken any bones or significantly sprained any part of your body?_____
_____
7. Please list any herbs, nutritional supplements or other natural remedies you take regularly_____
_____
8. Have you consulted a physician or any other health care provider in the past three months?_____
9. Has your spine ever been professionally adjusted/manipulated/entrained?_____
    1. By whom?_____
    __
    2. When?_____
    3. Why did you go?_____
    4. What did he/she do for you?_____
    5. Were you happy with the treatment?_____
    6. Have you ever received Network Spinal Analysis care?_____
    7. Has anyone in your family received Network care?_____
10. Did you consult with a physician for any other reason than a routine check up? _____
    What was the reason for the visit?_____
    ---_
    What was done or suggested?_____
    _____
    When was your last visit?_____
11. Have you had any experience with the following treatments/modalities? (circle)

Massage/Bodywork
Psychotherapy/Emotional therapy
Osteopathy
Physiotherapy/Occupational Therapy
Music/dance/sound/light/aromatherapy
Homeopathy/Herbalist
Ayurvedic Medicine
Oriental Medicine/Acupuncture
Nutritional Counseling
Oxygen therapy/Chelation
Rebirthing/Breath work
Yoga/Dance/Tai chi/Chi Gong
Somato Respitory Integration Care
Other?

12. Do you have an exercise, meditation, prayer, nutritional or dietary program?_____
_____
13. When stressed, how do you “center” or regroup?_____

_____

Part III: Stress Survey

Please rate the following stresses in order of increasing intensity:
0- No awareness of stress 1- Slightly stressful 2- Moderately stressful 3- Extremely stressful

1. Overall Physical Stress/trauma Includes falls accidents, injuries, repeated postural stress
   0 1 2 3 impacts, difficult birth, traction, physical abuse
2. Overall Emotional/Mental Stress Includes loss of loved ones, rapid changes in life situation,
   0 1 2 3 mental, emotional, sexual abuse, legal concerns, financial concerns, move of home OR school,separation/divorce, relationship issues, stress of being ill
3. Overall Chemical Stress Includes drugs, alcohol, smoke, fumes, food additives
   0 1 2 3
4. Have you ever had a work/vehicular accident related injury?_____

Part IV: Your specific needs and hopes for help in this office

In a published study of over 2,800 in Network Care (Medical College of UC-Irvine) patients reported an overall improvement in all of the categories of health and wellness listed below. In questions 1 & 2, please rate the choices using this scale:
0- not important 1- somewhat important 2- Very important

1. How do you hope to benefit from care in this office?(√)

Improvement of my physical symptoms_____
Improvement of my emotional/mental symptoms_____
Improvement of my ability to react/respond to stress_____
Improvement in enjoyment of life and the ability to make constructive choices_____
Overall improvement in quality of life_____

2. For a slightly longer-term goal. How do you hope to benefit from care in this office?(√)

Improvement of my physical symptoms_____
Improvement of my emotional/mental symptoms_____
Improvement of my ability to react/respond to stress_____
Improvement in enjoyment of life and the ability to make constructive choices_____

3. Is there some aspect of your life that very much pleases you, brings you joy, or helps you 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 about your life experiences, family, work, recreation, past injuries, genetics, dietary programs, exercise, outlook, etc that you feel give you an edge or add to your health?_____

_____

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

6. When communicating to you about your spine, nervous systems, health and wellness, please circle your preference.

a. Mostly speak with me about the clinical findings. Tell me about the changes I am making_____
b. Mostly show me in a written form the clinical findings. Let me see the changes I am making_____
c. Mostly let me get a sense of the clinical work. Help me to feel a difference in my body_____

7. Is there anything else which may help us to better understand you, your history or your professional needs which have not been addressed on this survey?_____
_____

8. What would motivate you to communicate to others about the care you receive in this office and to encourage others to seek care?_____
_____
_____
___

Thank you for choosing our office. We are looking forward to helping you to be successful in your ability to develop new strategies for a healthy spine, nervous system and life. We are excited about the possibility of assisting you as you continue on your journey towards greater health and wellness.