A Garden for Wellness
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Comprehensive Health Profile

Date: _____
Last Name: _____
First Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____
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, symptoms, and how they 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 affect 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: 0 1 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 of similar concerns?

_____

11: What did they do about them? _____

12: How aware of this concern are you: During the day? 0 1 2 3 During 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 / less aware of this concern?

_____

15: Why do you think this has 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 different because of this concern?

_____

20: Since the development of this concern:

Have you changed any habits? _____

Held or touched your body more often or differently? _____

Moaned, cried, or made sounds you do not usually 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 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 healing.

5: Anything else? _____

22: Please grade using the following scale: 0: Not at all 1: Slight 2: Moderate 3: Extreme

How inconvenient is your concern? 0 1 2 3

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)

Date of most significant injury: _____

What happened? _____

Date of most recent injury: _____

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?

What did you take? _____

What was the reason for taking this medication? _____

4: Have you had any spinal X-rays, CT scans, or MRIs of your spine, head, neck, back, or hips?

When? _____

What were you told? _____

Do you have them? _____

5: Have you had any surgeries? If yes, please list them.

_____

_____

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 3 months?

_____

9: Has your spine ever been professionally adjusted, manipulated, or entrained? _____

By whom? _____

When? _____

Why did you go? _____

What did they do for you? _____

Were you happy with the treatment? _____

Have you ever received Network Spinal Analysis care? _____

Has anyone in your family received Network care? _____

10: Did you consult with a physician for any reason other 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 or 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

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 changes in life situation, mental, emotional, sexual abuse, legal concerns, financial concerns, move of home OR school, separation/ divorce, relationship issues, stress of being ill — 0 1 2 3

Overall Chemical Stress
Includes drugs, alcohol, smoke, fumes, food additives — 0 1 2 3

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 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, exercise, outlook, etc. that you feel impairs 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 gives you an edge or adds 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 check (√) your preference.

Mostly speak with me about the clinical findings. Tell me about the changes I'm making ___
Mostly show me in written form about clinical findings. Let me see the changes I'm making ___
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 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?

_____

_____

_____