Comprehensive Health Profile

Last Name:________________ **First Name:** ________________ **Today's Date:** ________________
Address:________________________ **City:**________________ **State:**______ **Zip:**__________
Home Phone:________________ **Work Phone**________________ **Occupation** ________________
E-Mail________________________ **Date of Birth**________________
How did you discover our office, and the professional services we offer?

____

Please complete this general health history survey, as it will provide your practitioner with important information to better understand your history, your present and longer term needs, and any compromise to your wellness or health related quality of life that you may now be experiencing.

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

1. Do you have a current health concern? If so please describe.

____

____

2. When did this situation or concern begin?________________________
3. Have you done anything about this situation or concern or gotten any advice or treatment for it? Yes No
   If yes, What were you told?________________________
4. What was done?________________________
5. Did it seem to work?________________________
6. What was different about <u>you</u>, after treatment?________________________
7. What was different about <u>your condition</u> or symptom after treatment?________________

____

8. What was different about your <u>concern about the condition or symptom</u> after treatment?________________

____

9. Please grade the level to which this health concern(s) effects these aspects of your functioning/quality of life.

0 - It does not seem to effect me. **1 - It seems to slightly effect me,**
2 - It seems to moderately effect me, **3 - It seems to drastically effect me.**

Effect on work	0 1 2 3	Effect on recreation/play	0 1 2 3	Effect on rest/sleep	0 1 2 3
Effect on social life	0 1 2 3	Effect on walking	0 1 2 3	Effect on sitting	0 1 2 3
Effect on exercise	0 1 2 3	Effect on eating	0 1 2 3	Effect on love life	0 1 2 3
Concern about particular symptom/condition			0 1 2 3	Concern about Health	0 1 2 3

Comments____

10. Have any other family members had the same or similar concerns? Yes No
    What did he/she do about them? ________________________
11. Did it seem to work?________________________
12. How aware of this are you during the day? 0 1 2 3 at night? 0 1 2 3
13. Is there any activity during which you totally, or almost totally, forget about this condition, symptom or concern? ________________________
14. Is there any time of day which makes you more/less aware the above?________________
15. Why do you think this has happened, or continues to happen to you?________________

____

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 condition/symptom/concern?

____

20. Since this happened: a) Have you 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?______________________

21. 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?______________________

22. Please grade the following on a scale of 0 to 3,
0-not at all, 1-slight, 2-moderate 3-extreme,
Currently, how inconvenient is your situation, condition or symptom? 0 1 2 3
a) 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 (neck, head, 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 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 3 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 or head (neck, back or hips)?
When?______________________

5. What were you told about them?______________________

6. Where are these films now?______________________

7. Have you had any surgeries? Please explain:______________________
____

8. Have you broken any bones, or significantly sprained part of your body? yes no
Please explain:______________________

9. Please list any herbs, nutritional supplements or natural remedies you take regularly.
____

10. Have you consulted a physician, or any other health care provider in the past three months?
____

11. Has your spine ever been professionally adjusted/manipulated/entrained? yes no
*a) By whom and when?*______________________
b) Why did you go? ______________________
c) Are you still going? yes no
d) What did he/she do for you? ______________________
____
e) Were you pleased? yes no
f) Has your family received Network Care? yes no

12. Do you consult with a physician for other than routine evaluations? yes no

13. *What is/was the reason for the visit(s)?*__________

14. *When was your last visit?* __________

15. *What was done or suggested?*__________

16. Have you had experience with the following health, treatment or healing modalities? If so, please describe when you went, for how long you went, and what the results were:

Massage/ Bodywork __________
Emotional Therapy/ Psychotherapy__________
Osteopathy__________
Physiotherapy/Occupational Therapy__________
Music/Dance/Sound/Light/Aromatherapy__________
Homeopathy/Herbalist __________
Ayurvedic Medicine__________
Oriental Medicine/ Acupuncture__________
Nutritional Counseling/Therapy__________
Oxygen Therapy/Chelation Therapy__________
Rebirthing/Breathwork__________
Yoga/ Movement/Dance/Tai Chi/ Chi Gong__________
Somato Respiratory Integration __________
Other__________

17. Do you have an exercise, meditation, prayer, nutritional or dietary program?
    Please describe: __________

18. When stressed, how do you "center yourself" or "re group"?

____

Part III Stress Survey: Please grade the following stresses in order of increasing intensity.

0- means no awareness of stress **1- slightly stressful situation**
2- moderately stressful situation **3- extremely stressful situation**

1) **Overall Physical Stress, Trauma:** 0 1 2 3
Includes: falls, accidents, injuries, repeated postural stress impacts, difficult birth, traction, physical abuse:

2) **Overall Emotional/Mental Stress:** 0 1 2 3
Includes: loss of love ones, rapid change in life situation, mental, emotional, sexual abuse, legal concerns, financial concerns, move of home/school, separation/divorce etc. in relationship, stress of being ill. etc.

3) **Overall Chemical Stress:** 0 1 2 3
Includes: drugs, smoke, fumes, food additives etc.
Comments:

4) Have you had a work/vehicular accident related injury? yes no
Please describe__________

Part IV: Your Specific Needs and Hopes For Help in This Office?

Use this scale for questions 1 and 2:

a) very important to me ***b) important to me***
c) not so important to me ***d) does not apply***

1. Which of the following five choices is currently of most interest to you. 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. How do you hope to benefit from care in the office?
   a)___ Improvement of my physical symptoms
   b)___ Improvement of emotional/mental symptoms
   c)___ Improvement of my ability to react or respond to stress
   d)___ Improvement in enjoyment of life and the ability to make constructive choices
   e)___ Overall improved quality of life
2. For a slightly longer term goal, how do you hope to benefit from care in the office?
   a)___ Improvement of my physical symptoms
   b)___ Improvement of emotional/mental symptoms
   c)___ Improvement of my ability to react or respond to stress
   d)___ Improvement in enjoyment of life and the ability to make constructive choices
   e)___ Overall improved quality of life
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 about your life: experiences, family, work, recreation, past injuries, genetics, dietary programs, exercises, outlook, etc. that *you feel give you an edge, or adds* to your health? ____
____

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

6. When communicating to you about your spine, nervous system, health and wellness:(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 written form the clinical findings. Let me see the changes that I am making
   c) Mostly let me get a sense of the clinical work. Help me to feel the difference in my body
7. Is there anything else which may help us to understand you, your history, or your professional needs which have not been discussed on this survey? Please explain:____
____
8. What would motivate you to tell others about the care you receive in this office, and encourage others to get in care? ____

Thank you for choosing our Network Spinal Analysis Office. We are looking forward to helping you to be successful in your ability to develop a healthy spine and nervous system.

We are excited about the possibility of assisting you as you continue on your journey towards greater health and wellness.