

# 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 you after treatment? \_\_\_\_\_
7. What was different about your condition or symptom after treatment? \_\_\_\_\_
8. What was different about your concern about the condition or symptom 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

j) 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, 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:** 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 love ones, rapid change in life situation,

0 1 2 3      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:** Includes: drugs, smoke, fumes, food additives etc.

0 1 2 3      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 b c d Improvement of my physical symptoms
- a b c d Improvement of emotional/mental symptoms
- a b c d Improvement of my ability to react or respond to stress
- a b c d Improvement in enjoyment of life and the ability to make constructive choices
- a b c d Overall improved quality of life

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

- a b c d Improvement of my physical symptoms
- a b c d Improvement of emotional/mental symptoms
- a b c d Improvement of my ability to react or respond to stress
- a b c d Improvement in enjoyment of life and the ability to make constructive choices
- a b c d 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.***