COMPREHENSIVE HEALTH PROFILE

Last Name:_____ **First Name:**_____ **Date:**_____
Address:_____ **City:**_____
Zip Code:_____ **Occupation:**_____
Home Phone:_____ **Work Phone:**_____ **Cell Phone:**_____
Email:_____ **Date of Birth:**_____
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 wellness or health related 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? If so, please describe: _____
_____
_____
_____ _____
2. When did this situation/concern/symptom begin?_____
3. Have you done anything about this situation/concern, been given 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 situation/concern/symptom after treatment?_____
_____
8. Has your situation/concern/symptom changed since treatment?_____
_____
9. Please grade the level to which this health concern(s) affects these aspects of your functioning/quality of life:

0 – it does not seem to affect me **1 – it seems to slightly affect me**
2 – it seems to moderately affect me **3 – it seems to drastically affect me**

Work	0 1 2 3	Recreation/Play	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 this particular situation			0 1 2 3	Concern about health	0 1 2 3

Comments:_____
10. Has any other family member(s) had the same or similar concerns? Yes__ No__
If yes, 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 situation/concern/symptom?
_____
14. Is there any time of day which makes you more/less aware of 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 situation/concern/symptom were to go away tomorrow, what would be different in your life?_____
_____

19. Are you doing anything differently because of this situation/concern/symptom?_____
_____
20. Since the development of this situation/concern/symptom have you:
(a) changed any habits? If so, what?_____ Yes___ No___
(b) held or touched parts of your body more often or differently? Yes___ No___
(c) moaned, cried, or made sounds that you usually do not make? Yes___ No___
21. Which best describes your current feeling about yourself and your situation/concern/symptom:
__ I feel helpless, like little or nothing works.
__ This is terrible, really bad; I am scared and I hope you can fix it for me.
__ I feel stuck and can't help myself right now.
__ I deserve more than what I have been experiencing, and I would like you to assist me in my healing.
Anything else? _____
22. Please grade the following in order of increasing intensity:

0 - not at all	**1 – slight**	**2 – moderate**	**3 - extreme**
Currently, how inconvenient is your condition/symptom/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 (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 90 days:_____
_____
3. In past, have you taken other medications for period 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 spinal X-rays, CT scans, or MRI imaging of your: neck, head, back, hips? Yes__ No__
If yes, when?_____
5. What were you told about them?_____
6. Where are these films now?_____
7. Have you had any surgeries? Yes__ No__
If yes, please explain:_____
8. Have you broken any bones or significantly sprained a part of your body? Yes__ No__
If yes, 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 3 months? Yes__ No__
If yes, please explain:_____
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) Have you received Network Spinal Analysis Care? Yes__ No__
(g) Has your family received Network Spinal Analysis Care? Yes__ No__
12. Do you consult with a physician for any 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 experienced the following health treatments or healing modalities? If so, please describe when you went, for how long you went, and what the results were:

__ Chiropractic_____

__ Bodywork/Massage_____

__ Emotional Therapy/Psychotherapy_____

__ Osteopathy/Cranial work_____

__ Physiotherapy/Occupational Therapy_____

__ Music/Dance/Sound/Light/Aromatherapy_____

__ Homeopathy/Herbalist_____

__ Ayurvedic Medicine_____

__ Oriental Medicine/Acupuncture_____

__ Nutritional Counseling/Therapy_____

__ Oxygen Therapy/Chelation Therapy_____

__ Rebirthing/Breathwork_____

__ Meditation/Yoga/Prayer/Movement/Dance/Tai Chi/Chi Gong or Exercise_____

__ Somato Respiratory Integration Care_____

__ Other_____

17. Do you have an exercise, meditation, prayer, nutrition, or dietary program? Yes__ No__

If yes, please describe:_____

18. When stressed, how do you "center yourself" or "regroup?"_____

_____

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 situation**

1. Overall physical stress, trauma (includes falls, accidents, injuries, repeated postural stress impacts, difficult birth/traction, physical abuse? 0 1 2 3

2. Overall emotional/mental stress (includes loss of loved ones; rapid change in life situation; mental, emotional, sexual abuse; legal concerns, financial concerns; move of home/school; separation/divorce in relationship; stress of being ill)? 0 1 2 3

3. Overall chemical stress (includes drugs, smoke, fumes, food additives)? 0 1 2 3

4. Have you had a work/vehicular accident related injury? Yes__ No__

If yes, 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:

a – very important to me **b – important to me**

c – not so important to me **d – does not apply to me**

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 or respond to stress

__ Improvement in enjoyment of life and the ability to make constructive choices

__ Overall improved 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 or respond to stress
__ Improvement in enjoyment of life and the ability to make constructive choices
__ 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 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, exercises, 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, 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 better understand you, your history, or your professional needs, that have not been addressed on this survey? Please explain: _____
_____

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 Network Spinal Analysis office. We are looking forward to helping you to become 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.

Signature_____ Date (MM/DD/YYYY)_____