Comprehensive Health Profile

Date: _____ / _____ / _____

Name: _____ Address: _____

City: _____ State: _____ Zip: _____ Occupation: _____

Home Phone: _____ Business Phone: _____

Cell Phone: _____(Used only if we need to change an appointment)

Date of Birth: _____ Age: _____ Height: _____ Weight: _____ Marital Status: S M W D

Number of Children: ____ Email:_____(used for educational purposes and important announcements)

Do you want to receive our monthly educational newsletter?___Yes ____ No (we do not share your email with anyone)

Who referred you to our office and the professional services we offer? _____

Have you received any type of chiropractic care in the past? ☐Yes ☐No Were you pleased with their care? ☐Yes ☐No

If yes, why did you discontinue your chiropractic care? _____

PLEASE ANSWER THE FOLLOWING QUESTIONS ABOUT YOUR PERSONAL HISTORY

1) Why are you here (Health Concern)? _____

_____

_____

2) Please grade and circle the level to which this health concern(s) affects the following 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.**

Affect on Work	0 1 2 3	Affect on Recreation/Play	0 1 2 3	Affect on Rest/Sleep	0 1 2 3
Affect on Social Life	0 1 2 3	Affect on Walking	0 1 2 3	Affect on Sitting	0 1 2 3
Affect on Exercise	0 1 2 3	Affect on Eating	0 1 2 3	Affect on Love Life	0 1 2 3
Concern about Particular Symptom/Condition	0 1 2 3	Concern about Health/Well-Being	0 1 2 3		

3) Have you done anything or sought treatment for this situation or concern? ☐Yes ☐No If yes, what were told? _____

_____

4) What was done? _____ Did it seem to work? _____

5) What was different about your **CONDITION** or **SYMPTOM** after treatment?_____

6) What was different about **YOU**, after treatment?_____

7) Why do you think this has happened (or continues) to happen to you? _____

Do you think this is the sole cause? ☐Yes ☐No

If no, what else is involved? _____

8) How do you feel about your current condition? (Please choose **ONE** that **BEST** describes how you feel)

☐ I feel helpless; nothing works.
☐ I don't like what I am feeling, and I hope you can fix it.
☐ I feel this is a pattern that has happened to me before; it is back again.
☐ I feel there is a message my body is giving me.
☐ I am looking for assistance in becoming healthier so I can move past my health concern.
☐ I realize my condition may be a necessary experience in getting to the real problem.
☐ I don't know how I feel. I am too preoccupied with my present condition.
☐ I am looking for something to help me enhance my quality of life and further enhance my wellness.

9) If this condition or symptom were to go away tomorrow, what activities would you be able to do again?_____

_____

10) What do you hope to receive from Network Care in this office? _____

_____

PHYSICAL HISTORY

BIRTH STRESS: Information about your birth history:

1) Did your mother have a difficult pregnancy with you? ☐Yes ☐No
2) Did your mother have any falls, accidents or physical injuries during pregnancy? ☐Yes ☐No
3) Was your birth traumatic? ☐Yes ☐No
4) Was your birth: ☐Drug induced ☐Forceps or Suction ☐Prolonged
   ☐"C" Section ☐Cord around the neck ☐Breech
   ☐Natural Fast Delivery ☐Other: _____
   Epidural Antibiotics
5) Describe any other physical or mechanical stress to your mother or you as labor progressed, delivery progressed, or as a newborn:_____

GENERAL PHYSICAL TRAUMA:

6) Were you ever knocked unconscious? ☐Yes ☐No How/When? _____
7) Have you ever broken any bones? ☐Yes ☐No Which Ones? _____
8) Have you ever had any impacts, falls, or jolts that you feel specifically may have injured your spine? ☐Yes ☐No
How / When? _____
9) Have you ever injured your head, neck, back or hips? ☐Yes ☐No How/When? _____
10) Have you served in the military? ☐Yes ☐No If yes, were you involved in combat? ☐Yes ☐No
11) On average, how many hours per day do you participate in the following? __Sitting __Standing __Desk Work
__Phone Work __Computer Work __ Driving __Lifting Heavy Objects __Manual Labor __Stooping/Bending/Kneeling

SPORTS OR LEISURE:

12) Were you, or are you active in any sport(s)? ☐Yes ☐No Which One(s)? _____
13) Have you been hurt in any of these activities? ☐Yes ☐No Where? _____

AUTOMOBILE ACCIDENTS:

14) Have you, (even as a passenger, even if you do not think you were hurt), been involved in a car accident, or near collision?
Please list approximate dates and severity (Mild, Moderate, Extreme).
Automobile: _____
Bus, bicycle, motorcycle, train, airplane, moped, or other vehicles: _____

MEDCIAL TREATMENT:

15) Have you ever been hospitalized? ☐Yes ☐No If yes, what was done to you? _____
16) Have you had surgery? ☐Yes ☐No If yes, what was done to you? _____
17) Do you have all of your body parts? ☐Yes ☐No If no, please describe: _____
18) Have you ever had: ☐Spinal Tap ☐Spinal Injections ☐Physiotherapy ☐Neck Collar ☐Spinal Brace ☐Traction
☐Heel Lift ☐X-Ray Treatments ☐Corrective Shoes or Bars ☐Extensive Diagnostic X-Rays
☐Acupuncture ☐Chemotherapy ☐Transfusion ☐Body Part in a Cast or Immobilized?
19) Are you/or have you ever been pregnant? ☐ No ☐Yes. How far along are you? _____

CHEMICAL HISTORY

BIRTH STRESS:

1) Was your mother regularly taking any drug immediately prior to, during, or after her pregnancy with you? ☐Yes ☐No

2) Did she use ☐Alcohol ☐Smoking ☐Other: _____

3) Was her labor chemically induced or altered? ☐Yes ☐No

4) Was your mother: ☐Conscious ☐Semi-Conscious ☐Unconscious during delivery ☐Under spinal anesthesia during delivery?

5) Any other chemical stresses that your mother may have been subject to during pregnancy or labor? _____

_____

GENERAL CHEMICAL TRAUMA:

6) Are you now taking any drug(s) (prescription or over-the-counter) regularly? Please list drug(s), when prescribed and reasons for taking them: _____

7) Were you previously taking any medication regularly? Which Ones / How Long?_____

_____

8) Do you now, or in the past have a history of alcohol / drug abuse or heavy use? ☐Yes ☐No

Please describe: _____

9) Do you or did you work with any chemical, fume, dust, powder, smoke for prolonged periods? ☐Yes ☐No

10) Please indicate how much of the following products you consume:

Alcohol - Drinks/Week: ___ Coffee – Cups/Day: ___ Tobacco – Amount/Day: _____

Artificial Sweeteners ☐Yes ☐No Soda - #/Day: ___ Refined Sugar – Candy/Pastries/Day: _____

EMOTIONAL HISTORY

BIRTH STRESS:

1) My birth was: ☐At Home ☐In a Birthing Center ☐In a Hospital ☐Other

2) Were you incubated or isolated after birth? ☐Yes ☐No

3) Were you: ☐Bottle Fed Formula ☐Bottle Fed Mothers Milk ☐Nursed - How Long? _____ ☐Nursed and Bottle Fed?

GENERAL EMOTIONAL TRAUMA:

4) With each of the following potential spinal stress situations, please indicate the severity either past or current.

Potential Spinal Stress/Tension Sources	PAST	CURRENT
Childhood Stress	☐Mild ☐Moderate ☐Extreme	☐Mild ☐Moderate ☐Extreme
School Stress	☐Mild ☐Moderate ☐Extreme	☐Mild ☐Moderate ☐Extreme
Family Stress	☐Mild ☐Moderate ☐Extreme	☐Mild ☐Moderate ☐Extreme
Personal Relationships	☐Mild ☐Moderate ☐Extreme	☐Mild ☐Moderate ☐Extreme
Stress of Being Sick	☐Mild ☐Moderate ☐Extreme	☐Mild ☐Moderate ☐Extreme
Work Stress	☐Mild ☐Moderate ☐Extreme	☐Mild ☐Moderate ☐Extreme
Stress of Commuting	☐Mild ☐Moderate ☐Extreme	☐Mild ☐Moderate ☐Extreme
Loss of Loved One	☐Mild ☐Moderate ☐Extreme	☐Mild ☐Moderate ☐Extreme
Change in Lifestyle	☐Mild ☐Moderate ☐Extreme	☐Mild ☐Moderate ☐Extreme
Change in Vocation	☐Mild ☐Moderate ☐Extreme	☐Mild ☐Moderate ☐Extreme
Abuse (Verbal, Physical, Emotional, Sexual, etc)	☐Mild ☐Moderate ☐Extreme	☐Mild ☐Moderate ☐Extreme

Questionaire continues on the next page

OVERALL STRESS SURVEY

Please grade your Past/Current Life Stresses using the following scale:

0 - *No* awareness of any stress **1 - *Slightly* stressful** **2 - *Moderately* stressful** **3 - *Extremely* stressful**

A) ***Overall Physical Stress/Trauma:*** (includes: falls, accidents, injuries, repeated postural stress, impacts, difficult birth, physical abuse, loss of consciousness, broken/fractured bones, etc.)
0 1 2 3

B) ***Overall Emotional/Mental Stress:*** (includes: loss of loved ones, rapid change in life situations, abuse, move of home/school, legal concerns, financial concerns, divorce, relationships, etc)
0 1 2 3

C) ***Overall Chemical Stress:*** (includes: prescription drugs, smoke, alcohol, caffeine, fumes, food additives, anesthesia from surgery, over-the-counter medications, etc.)
0 1 2 3

Please list any herbs, nutritional supplements, or natural remedies you take regularly:_____

_____

Do you have an exercise, meditation, prayer, nutritional or dietary program?_____

_____

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

_____

YOUR SPECIFIC NEEDS AND HOPES FOR HELP IN THIS OFFICE?

1) In published study of health and wellness benefits for patients under Network Care, conducted at the University of California, Irvine Medical College, patients reported an overall improvement in all of the following categories of health and wellness listed below (highlighted in **BOLD**). How do you hope to benefit from care in this office? (use scale below to answer each category)

A) *Very important to me* B) *Important to me* C) *Not so important to me* D) *Does not apply*

_____ Improvement of my **Physical Symptoms.**

_____ Improvement of **Emotional/Mental Symptoms.**

_____ Improvement of my **Ability to React or Respond to Stress.**

_____ Improvement in **Enjoyment of Life** and the ability to make **Healthier, more Constructive Choices.**

_____ Overall improvement in **Quality of Life.**

2) Is there anything else you may wish to share which may help us to better understand you, your history, or your professional and personal needs which have not been discussed in this profile? (If necessary, please use the bottom of this form)_____

_____

_____

3) What would motivate you to tell others about the care you receive in this office and encourage others to get under Network Care?

_____

_____