# Comprehensive Health Profile

**Last Name:__________________ First Name:___________________________ Today's Date:____________________**
**Address:______________________________________City:_____________________State:________Zip:__________**
**Home Phone:________________________________ Work Phone:__________________________________**
**E-Mail:_______________________________________________ Date of Birth:________________**
**Spouse/Partner:__________________________________________**
**Children and ages:__________________________________________________________________________________**

How did you discover our office and the professional services we offer?
____________________________________________________________________________________________

*Please complete this general health history survey, as it will provide your doctor 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 Concerns or Symptoms and How They May Affect Your Life**

1.Do you have any current health concerns? 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) 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.**

| | | | | | |
|---|---|---|---|---|---|
| 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 | 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 time, or activity you can be involved with when you totally or almost totally forget about this condition, symptom or your concern about this?________________________________________________________________
14. Is there any time of day or activity which makes you more aware of it?______________________________________
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. What are your doing in your life now that is different than if you did not have this condition/symptom?
______________________________________________________________________________

20. Since this happened:
a)Have you any changed habits?________________________________________________
b)Held, or touched part of your body more 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 |
| 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, CAT scans or MR imaging of your spine or head (neck, back or hips)?__________
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? 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) Does your family receive chiropractic 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:

**0- no awareness of any 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 a relationship, stress of being ill, etc.

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

4) Have you had a work/car accident related injury? yes no
Please describe____________________

Do you belong to a Health Club or have a home exercise routine? _____ How often do you
What kind of water do you drink? ______

Do you eat organic food? _______ If yes, what percent? ________

## 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. 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?

__ 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 constructive choices
__ Overall improved quality of life

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

__ 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 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 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 guide 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 and tell me about the changes I am making
b) Mostly show me in written form the clinical findings, and 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 that 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 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.***