Comprehensive Health Profile

Date: _____ / _____ / _____

Name: _____ Address: _____

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

Home Phone: _____ Business Phone: _____ Email: _____

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

Number of Children: ____ Social Security Number: _____ Insurance: _____

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) Do you currently have any health concerns? ☐Yes ☐No Please Describe: _____

_____

_____

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.**

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/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 you told? _____

_____

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

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

6) What was different about your **CONDITION** or **SYMPTOM** 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) What do you hope to receive from Network Care in this office? What are your healthcare goals and desires? _____

_____

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

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 ☐Other: _____
5) Describe any other physical or mechanical stresses 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: _____

MEDICAL 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?

CHEMICAL HISTORY

BIRTH STRESS:

1) Was your mother regularly taking any drugs immediately prior to, or during 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

YOUR SPECIFIC NEEDS AND HOPES FOR HELP IN THIS OFFICE

4) *Very important to me* 3) *Important to me* 2) *Not so important to me* 1) *Does not apply*

1) In a 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 from above to answer each category)

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 **Healthier, more Constructive Choices.**

e) _____ 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 back 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?

_____