

Comprehensive Health Profile

Last Name: _____ First Name: _____ Date: _____
Address: _____ City: _____ State: _____
Zip: _____ Home Phone: _____ Work Phone: _____
E-Mail: _____ Date of Birth: _____ Occupation: _____

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 or concern? If so, please describe:

2. When did this situation or concern begin? _____

3. Have you done anything about this situation or concern or been given 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. Have your concerns 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 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 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 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 the development of this condition/symptom/concern:
- 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
- a) Currently, how inconvenient is your situation, condition, or symptom? 0 1 2 3
 - b) 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 60 days: _____
3. In the past, have you taken other medications for a period of 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 any spinal X-rays, CT scans, or MRI imaging of your spine, head, neck, back, or 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 Please explain: _____
8. Have you broken any bones or significantly sprained any 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? Yes No
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 reason 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 treatments 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™ Care _____
- Other: _____
17. Do you have an exercise, meditation, prayer, nutritional, or dietary program? Yes No
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 etc. in relationship; stress of being ill; etc.
0 1 2 3

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:

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
c) Not so important to me

b) Important to me
d) Does not apply

1. How do you hope to benefit from care in the office?
 - 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 constructive choices
 - e) ___ Overall improved quality of life

2. For a slightly longer term goal, how do you hope to benefit from care in the office?
 - 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 constructive choices
 - e) ___ 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 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.