Comprehensive Health Profile

HEALTH, VITALITY AND COMMUNITY

Date: Y Y / M M / D D

Last Name: First Name: Date of Birth: Y Y / M M / D D

Address: City: State: Zip:

Home Phone: Work Phone: Cell Phone:

Email: Occupation: SSN:

Marital Status: S M D W Spouse's Name: Do you have children? Y / N

Who referred you or how did you hear about our office?

Do you have insurance you want us to bill for your care?

What are your reasons for seeking care at our office? Please rank the following:

4=Very Important to me; **3**=Important to me; **2**=Not so Important to me; **1**=Does not apply

___Improvement of my physical symptoms
___Improvement in my ability to respond to stress
___Improvement of my emotional/mental symptoms
___Improvement in my enjoyment/quality of life

Your Symptoms and How They May Influence Your Life

Do you have a current health/life concern or symptom? If no, skip to History of Physical Stress Section.
If yes, please describe:

When did it begin?

What were the circumstances?

Is the reason you are consulting our office the result of an injury at work or an auto accident? Y / N

If so, date of injury? ____________________

Have you done anything about this concern, or been given any advice or treatment for it? Y / N
If yes, what were you told and by whom?

____

____

What was done? ____________________

Did it seem to work? Y / N What was different about your symptom or concern after treatment?

____

____

Please grade the level to which the concern/symptom affects the following aspects of your functioning/quality of life:
0=does not seem to affect me; **1**=slightly affects me; **2**=moderately; **3**=extremely

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

Comments: ____________________

Have any other family members had the same or similar concerns? Y / N What did he/she do about it?

____

Did it seem to work? Y / N How aware are you of your symptom/concern during **the day**? 0 1 2 3 **at night**? 0 1 2 3

Is there any activity during which you totally, or almost totally, forget about this condition, symptom, or concern?

____

Why do you think this is happening, or continues to happen to you?

____

Do you think this is the sole cause? Y / N If no, what else is involved?

____

____

Are you doing anything differently in your life because of this symptom/condition/concern? **Y / N** If yes, what?

If it were to go away tomorrow, what would be different about your life?

Since the development of this symptom/concern, have you:

Changed any habits? **Y / N** If so, what?

Held or touched a part of your body more often or differently? **Y / N**

Moaned, cried, or made sounds that you usually do not make? **Y / N**

Which best describes your current feeling about yourself and your situation?

- ○ I feel helpless, like little or nothing is working.
- ○ This is terrible, really bad; I hope you can fix it for me.
- ○ I feel stuck.
- ○ I deserve more than this, and would like you to assist me with my healing.
- ○ Other, please describe:

History Of Physical Stress

Birth Stress: Were there any problems associated with your mother's pregnancy with you? (check all that apply)

- ○ Falls/Injury
- ○ Illness Difficult
- ○ Don't know

Comments:

Was your birth: (check all that apply)

○ Traumatic	○ "C" section	○ Breech	○ Forceps or Suction
○ Cord around neck	○ Prolonged	○ Very Fast	○ Natural
○ Drug induced	○ Home	○ Hospital	○ Birthing Center

Comments:

General Physical Trauma: Falls: (check all that apply, give age & year)

- ○ Crib/Carriage age ________ year ________
- ○ On ice age ________ year ________
- ○ Bars at school age ________ year ________
- ○ Steps age ________ year ________
- ○ Out of Tree age ________ year ________
- ○ Skiing/Snowboarding age ________ year ________
- ○ Other falls (please describe):________________________________
- ○ Knocked unconscious age ________ year ________
- ○ Used crutches/cane age ________ year ________
- ○ Broken Bones/Sprains (please describe):________________________________
- ○ Involved in combat age ________ year ________
- ○ Physical abuse age ________ year ________
- ○ Extensive dental work/orthodontia age ________ year ________
- ○ Physical fight age ________ year ________
- ○ Sports Injuries age ________ year ________
- ○ Other, please describe:________________________________

Accidents, near accidents, driver or passenger: (check all that apply, give age & year)

Automobile, details:

- ○ Motorcycle age ________ year ________
- ○ Train age ________ year ________
- ○ Plane age ________ year ________
- ○ Bus age ________ year ________
- ○ Bicycle age ________ year ________
- ○ Other:

Comments:________________________________

Daily Activities: (check all that apply)

- ○ Sit ○ Stand ○ Walk ○ Desk work ○ Phone work
- ○ Sports ○ Exercise ○ Computer work ○ Watch TV ○ Driving/commuting
- ○ Play musical instrument ○ Read for prolonged periods ○ Mechanical work
- ○ Heavy lifting ○ Wear contacts ○ Wear glasses ○ Wear bifocals

Comments:________________________________

Medical Intervention: (check all that apply, give age & year)

- ○ Hospitalization *why?* age ________ year ________ ________________________________
- ○ Surgery *why?* age ________ year ________ ________________________________

- ○ Chemotherapy age ________ year ________
- ○ Casts/Collars age ________ year ________
- ○ Corrective shoes. bars, lifts age ________ year ________
- ○ Spinal tap/injections age ________ year ________
- ○ Transfusion age ________ year ________
- ○ Radiation age ________ year ________
- ○ Spinal/neck brace age ________ year ________
- ○ Physical Therapy age ________ year ________
- ○ X-rays age ________ year ________
- ○ Organ Removal age ________ year ________

Comments: ______________________________

Have you or a family member suffered a serious illness? ______________________________

Do you have a family doctor? Y / N Who? ______________________________

Date of last medical consultation & result: ______________________________

For women: Are you pregnant? Y / N Date of last monthly period: ______________________________

How do you grade your overall physical health?

○ Excellent ○ Good ○ Fair ○ Poor ○ Getting Better ○ Getting Worse

History Of Chemical Stress

Birth Stress: During your mother's pregnancy, did she: (check all that apply)

- ○ Use prescription drugs
- ○ Use nonprescription drugs
- ○ Smoke
- ○ Consume alcohol/drugs
- ○ Don't know

At birth was your mother: (check all that apply)

- ○ Conscious
- ○ Semi-conscious
- ○ Unconscious
- ○ Given spinalanesthesia
- ○ Given chemicals to alter or induce labor
- ○ Don't know

General Chemical Stress: Do you or have you ever taken: (check all that apply)

- ○ Prescription drugs
- ○ Over-the–counter drugs
- ○ Antibiotics
- ○ Other drugs
- ○ Tobacco

List all current and past Medications: (include reason and length of time you were on them)

____

____

Do you or have you worked with or ever been exposed to:

- ◯ Chemicals
- ◯ Fumes
- ◯ Dust
- ◯ Powders/Particles
- ◯ Smoke
- ◯ Other substances

Do you consume:

- ◯ Alcohol
- ◯ Coffee/caffeine
- ◯ Processed food
- ◯ Artificial sweeteners
- ◯ Refined sugar
- ◯ Sodas
- ◯ Tap water

Describe diet: ______________________________

____

History Of Emotional Stress

Were you incubated or isolated after birth? Y / N   Were you: ◯ Bottle fed ◯ Nursed ◯ Both

PAST General Emotional Trauma: (check all that apply and note severity: **mild, moderate, extreme**)

- ◯ Childhood ______________
- ◯ Change of job/career ______________
- ◯ Divorce/separation ______________
- ◯ Recreational ______________
- ◯ Loss of loved one ______________
- ◯ Commuting ______________
- ◯ Family ______________
- ◯ Stress of being sick/ill ______________
- ◯ Personal relationship ______________
- ◯ School ______________
- ◯ Change of lifestyle ______________
- ◯ Work related ______________
- ◯ Parent's divorce ______________
- ◯ Abuse ______________
- ◯ Financial ______________

Comments: ______________________________

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LIFESTYLE PROFILE

How do you grade your emotional/mental health?

◯ Excellent ◯ Good ◯ Fair ◯ Poor ◯ Getting Better ◯ Getting Worse

How do you grade your overall quality of life?

◯ Excellent ◯ Good ◯ Fair ◯ Poor ◯ Getting Better ◯ Getting Worse

Have you pursued other avenues of growth, healing or personal development?
(check all that apply and note who you saw, for how long and if you are still going)

◯ Chiropractic Acupuncture ____________________
◯ Massage/Bodywork Homeopathy ____________________
◯ Psychotherapy Ayurvedic Medicine ____________________
◯ Osteopathy Physical Therapy ____________________
◯ Aromatherapy Energy Work ____________________
◯ Rebirthing Sound/Light Therapy ____________________

What aspects of your life please you, bring you joy, and help you to feel better about yourself?

____

____

What particular factors or elements about your life experiences, family, work, recreation, past injuries, genetics, dietary programs, exercises, outlook, etc.:

Do you feel impair your opportunity for full glowing health? ____________________

____

Do you feel give you an edge or add to your life and health? ____________________

____

Which of the following do you practice regularly (check all that apply and how many times per week)

◯ Exercise ________ ◯ Yoga ________ ◯ Chi Gong/Tai Chi ________
◯ Movement/Dance ________ ◯ Meditation ________ ◯ Prayer ________

List any herbs, nutritional supplements or natural remedies you regularly take:

____

When stressed how do you “center yourself” or “re-group”?

____

Is there anything else you wish to share which may help us better understand you and why you have chosen to come to this office?

What type of results would motivate you to tell others about the care you receive in this office, and encourage others to get under care?

When communicating with you about your spine, nervous system, health and wellness (circle your preference):

a) Visual Communication- Mostly show me pictures and diagrams.

b) Verbal Communication- Mostly talk to me about the changes I'm making.

c) Kinesthetic Communication- Mostly I need to feel it.

Life Intention

We are committed to helping you reach and exceed your health and life goals. We know that a true state of Well-Being is possible for you. If your life were "perfect" in every way what would you be doing? What would you be like physically, emotionally, mentally, financially, relationally and spiritually?