Comprehensive Health Profile

Date: _____ / _____ / _____

Name: _____ Occupation:_____

Address: _____

City: _____ State: _____ Zip: _____

Best number to reach you or leave a message: home/work/cell (_____)_____-_____

Email: _____ Date of Birth: ___ /___ /___

Marital Status S M W D Names/Ages Children: _____

Who referred you to our office? _____

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? _____

Are you currently consulting a physician or any other health care provider (psychotherapy, massage, etc) ? ☐Yes ☐No If Yes, please explain:_____

_____

PLEASE ANSWER THE FOLLOWING QUESTIONS ABOUT YOUR PERSONAL HISTORY

1) Are there any areas of your life you would like to see change? ☐Yes ☐No If Yes, please describe:

_____

_____

2) Do you currently have any health concerns? ☐Yes ☐No If Yes, please describe: _____

_____

_____

3) 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	Daily Awareness	0 1 2 3

4) Have you done anything or sought treatment for this concern? ☐Yes ☐No

If Yes, what were you told? _____

_____

5) What was done? _____

Did it seem to work?_____

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

7) What was different about your **CONCERN** or **SYMPTOM** after treatment? _____

_____

8) Why do you think this has happened, or continues to happen, to you? _____

_____

9) Do you think this is the sole cause? ☐Yes ☐No If No, what else is involved? _____

_____

10) Is there any time, or activity you can be involved with, when you forget about your concern or symptom?_____
11) If this concern or symptom were to go away tomorrow, what would be different about your life?
_____
12) Do you have an exercise, meditation, prayer or nutritional/dietary practice? ☐Yes ☐No If Yes, please describe:_____
13) When stressed, how do you "center yourself" or "re-group"? _____
14) Which of the following BEST describes your current situation? (Please choose only **ONE**)
☐ 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 wellness.
15) What do you hope to receive from Network Care in this office? _____
_____

PHYSICAL HISTORY

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

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

Overall Physical Stress/Trauma: 0 1 2 3

(Includes: falls, accidents, injuries, repeated postural stress, impacts, difficult birth, physical abuse, loss of consciousness, fractures, sprains, etc.)

BIRTH STRESS: Information about your birth history:
1) Did your mother have a difficult pregnancy with you? ☐Yes ☐No
2) Did she have any falls, accidents or physical injuries during pregnancy? ☐Yes ☐No
3) Was your birth traumatic? ☐Yes ☐No
4) Was your birth: ☐Drug induced ☐"C" Section ☐Prolonged
☐Forceps or Suction ☐Natural ☐Breech
☐Cord around Neck ☐Other: _____
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 If Yes, how/when? _____
_____
7) Have you ever broken any bones? ☐Yes ☐No If Yes, which one(s)?_____
_____
8) Have you ever had any impacts, falls, or jolts that you feel specifically may have injured your spine? ☐Yes ☐No If Yes, how/when?_____
9) Have you ever injured your head, neck, back or hips? ☐Yes ☐No If Yes, how/when? _____
_____
10) Have you served in the military? ☐Yes ☐No If Yes, were you involved in combat?
☐Yes ☐No Details: _____
11) On average, how many hours per day (24 hrs) do you participate in the following?
___Sitting ___Standing ___Desk Work ___Phone Work ___Computer Work
___Driving ___Manual Labor ___Lifting Heavy Objects ___Stooping/Bending/Kneeling

SPORTS OR LEISURE:

12) Were you, or are you, active in any sport(s)? ☐Yes ☐No If Yes, which one(s)?

_____

13) Have you been hurt in any of these activities? ☐Yes ☐No If Yes, when/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: _____

_____

Do you have any outstanding litigation? _____

MEDICAL TREATMENT:

15) Have you ever been hospitalized? ☐Yes ☐No If Yes, what was done? _____

_____

16) Have you had surgery? ☐Yes ☐No If Yes, what was done? _____

_____

17) Do you have all of your body parts? ☐Yes ☐No If No, please describe: _____

_____

18) Have you ever had: ☐Spinal Tap ☐Spinal Injections ☐Physical Therapy ☐Neck Collar ☐Spinal Brace ☐Traction ☐Shoe Inserts/Heel Lift ☐Corrective Shoes or Bars ☐Extensive Diagnostic X-Rays ☐Acupuncture ☐Chemotherapy ☐Transfusion ☐MRI ☐Body Part in a Cast or Immobilized?

CHEMICAL HISTORY

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

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

Overall Chemical Stress: 0 1 2 3

(Includes: prescription drugs, recreational drugs, over-the-counter (OTC) drugs, smoke, dust, alcohol, caffeine, fumes, food additives, anesthesia from surgery, etc.)

BIRTH STRESS:

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

2) Did she ☐Drink alcohol? ☐Smoke? ☐Other?:_____

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

4) During delivery, was your mother?

☐Conscious ☐Semi-Conscious ☐Unconscious ☐Under Spinal Anesthesia

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

GENERAL CHEMICAL TRAUMA:

6) Are you **now** taking any drug(s) (prescription, recreational, or OTC) regularly? ☐Yes ☐No

If Yes, please list drug(s), when prescribed and reasons for taking them: _____

_____

_____

7) Were you previously taking any medication regularly? ☐Yes ☐No If Yes, which ones / how long?_____

_____

8) Do you now, or in the past, have a history of alcohol and/or drug abuse? ☐Yes ☐No
If Yes, please describe: _____

9) Do you, or did you, work with any chemical, fume, dust, powder, etc. for prolonged periods?
☐Yes ☐No If Yes, please describe: _____

10) Please indicate how much of the following products you consume:
Alcohol: ___Drinks/Week Coffee: ___Cups/Day Tobacco: ____Cigarettes/Day
Soda: ____/Week Artificial Sweeteners ☐Yes ☐No List:_____

EMOTIONAL HISTORY

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

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

Overall Emotional/Mental Stress: 0 1 2 3

(Includes: loss of loved ones, rapid change in life situations, abuse, move of home/school, legal concerns, financial concerns, divorce, relationships, etc.)

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) For each of the following potential spinal stresses, indicate the severity either past or present:

Potential Spinal Stress/Tension Sources	PAST	PRESENT
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(s)	☐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, Neglect)	☐Mild ☐Moderate ☐Extreme	☐Mild ☐Moderate ☐Extreme

5) Is there anything else you may wish to share which may help us better understand you, your history, or your professional and personal needs which have not been discussed in this profile?

_____

_____

Thank you for choosing Network Care. We are looking forward to helping you be successful in your ability to develop a healthy spine and nervous system. We are excited about assisting you on your transformational journey toward greater health and wellness. WELCOME!!