Comprehensive Health Profile

Date: ________________

Name: _______________________________ Address: ____

City: ___________________State: __________ Zip: ___________ Occupation: _________________________________

Home Phone: ________________Business Phone: ________________ Email: _________________________________

Date of Birth: ___________Age:_____Height_______ Weight ________ Marital Status: ______

Number of Children: ______Social Security Number: ____________________ Insurance___________________________

How did you discover 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 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 / 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 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) Have any other family members had the same or similar conditions? ☐Yes ☐No If yes, what did he/she do about them? -

____

8) 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? ____

9) How do you feel about how you feel? (Please choose the ONE the BEST describes how you feel)

☐ I feel helpless; nothing works.
☐ I feel this is a terrible thing that has happened to me.
☐ I feel this is a terrible thing that has happened to me, 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 this is a pattern that has happened to me before; I feel stuck.
☐ I feel there is a message my body is giving me.
☐ I deserve more than this.
☐ I am going to move past this health concern by having the doctor treat it.
☐ I am going to move past this health concern by becoming healthier.
☐ I don't like what I feel, but I am O.K. with feeling what I am feeling because it may be necessary fro me to heal.
☐ I am ready to make changes in my life to become healthier and more whole.
☐ I have had enough and it is time to be well.
☐ I don't know how I feel about how I feel. I am too preoccupied with my present situation.

10) What do you hope to receive from Network care in this office? ____

____

The practice of Network Spinal Analysis (NSA) is based upon the location and entrainment of spinal system distortions. Spinal distortions are caused by any stress or tension your body can not properly perceive, adapt to or recover from. These stresses may be PHYSCIAL, CHEMICAL OR EMOTIONAL in nature.

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OVERALL STRESS SURVEY

Please grade the following stresses using the following scale:

0- No awareness of any stress **1-Slightly stressful situation**
2- Moderately stressful situation **4-Extremely stressful situation**

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 stress to your mother or you as labor progressed, delivery progressed, or as a newborn:______________________________

GENERAL PHYSICAL TRAUMA:

6) Next to each potential spinal system distortion cause is a check box (please check the most appropriate box):

Potential Cause of Spinal System Distortions	Mild		Moderate		Extreme	
	Past	Current	Past	Current	Past	Current
Falls from crib, carriage	☐	☐	☐	☐	☐	☐
Falls down or up steps	☐	☐	☐	☐	☐	☐
Falls on ice	☐	☐	☐	☐	☐	☐
Sports impacts	☐	☐	☐	☐	☐	☐
Physical fights	☐	☐	☐	☐	☐	☐
Armed services	☐	☐	☐	☐	☐	☐

7) Were you ever knocked unconscious? ☐Yes☐No Comments______________________________
8) Have you ever broken any bones? ☐Yes☐No Comments : ______________________________
9) Have you ever had any impacts, falls, or jolts that you feel specifically may have injured your spine? ☐Yes ☐No
Comments: ______________________________
10) Date of **most significant** spinal injury?____________ Date of **most recent** spinal injury?___________
11) Have you ever injured your head, neck, back or hips? ☐Yes ☐No
12) Date of **most significant** non-spinal injury?____________ Date of **most recent** non-spinal injury?___________
10) Have you served in the military? ☐Yes ☐No If yes, were you involved in combat? ☐Yes ☐No

SPORTS OR LEISURE:

11) Were you, or are you active in any sport(s)? ☐Yes ☐No Which one(s)?______________________________
12) Have you been hurt in any of these activities? ☐Yes ☐No Comments: ______________________________

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AUTOMOBILE ACCIDENTS:

13) Have you, (even as a passenger, even if you do not think you were hurt), been involved in a vehicular collision, or near collision? Please list approximate dates and severity (Mild, Moderate, Extreme).

Automobile: ______________________________

Bus, bicycle, motorcycle, train, airplane, moped, or other vehicles: ______________________________

MEDCIAL TREATMENT:

14) Have you ever been hospitalized? ☐Yes ☐No If yes, what was done to you? ______________________________ Have you had surgery? ☐Yes ☐No If yes, what was done to you? ______________________________

15) Do you have all of your body parts? ☐Yes ☐No If no, please describe______________________________

16) Have you ever had: ☐a spinal tap ☐spinal injections ☐physiotherapy ☐neck collar ☐spinal brace ☐traction ☐heel lift ☐x-ray treatments ☐corrective shoes or bars on shoes ☐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 drug 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 (prescription, or over-the-counter) regularly? Please list drugs, when prescribed and reasons for taking them: ______________________________

7) Were previously taking any medication regularly? Please describe: ______________________________

8) Do you or did you work with any chemical, fume, dust, powder, smoke for prolonged periods? ☐Yes ☐No

Please grade any dietary selection that is appropriate for you using the following scale:

O-Don't Consume this **M**-Consume this monthly **FM**-Consume a few times per month **W**-Consume this weekly	**FW**-Consume this a few times per week **D**-Consume this daily **FD**-Consume this a few times per day

Alcohol	Coffee	Tobacco
Artificial Sweeteners	Soda	Refined Sugar

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 ☐nursed and bottle fed?

GENERAL EMOTIONAL TRAUMA:

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4) With each of the following potential spinal stress situations, please check either past or current.

Potential Spinal Stress/Tension Sources	Mild		Moderate		Extreme	
	Past	Current	Past	Current	Past	Current
Childhood stress	☐	☐	☐	☐	☐	☐
School stress	☐	☐	☐	☐	☐	☐
Play, or recreation	☐	☐	☐	☐	☐	☐
Family stress	☐	☐	☐	☐	☐	☐
Personal relationships	☐	☐	☐	☐	☐	☐
Stress of being sick	☐	☐	☐	☐	☐	☐
Work related stress	☐	☐	☐	☐	☐	☐
Stress of commuting	☐	☐	☐	☐	☐	☐
Loss of loved one	☐	☐	☐	☐	☐	☐
Change in lifestyle	☐	☐	☐	☐	☐	☐
Change in vocation	☐	☐	☐	☐	☐	☐
Abuse (Verbal, Physical, Emotional, Sexual, etc)	☐	☐	☐	☐	☐	☐

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 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) For a slightly longer term goal, how do you hope to benefit from care in this 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 healthier, more constructive choices

e) _____ Overall improvement in quality of life

3) 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? ______________________________

____

4) What would motivate you to tell others about the care you receive in this office and encourage others to get under Network Care?

____

____