

# Comprehensive Health Profile

Date: \_\_\_\_\_

M F

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_ Occupation: \_\_\_\_\_

Married \_\_\_\_\_ Single \_\_\_\_\_ Children Y N How old? \_\_\_\_\_

Contact Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Add me to the newsletter/email list: Y N

Referred by: \_\_\_\_\_ SSN: \_\_\_\_\_

## Your Health Concern or Symptom(s)

1. Do you have a current symptom or health/life concern? \_\_\_\_\_
2. When did it begin? \_\_\_\_\_
3. Have you consulted or received treatment for this problem?  Yes  No
4. What was done? With what result? \_\_\_\_\_
5. Did your problem change?  Yes  No
6. Did you change?  Yes  No
7. Have your concerns about this problem changed?  Yes  No
8. Please grade the level to which this health concern(s) affects these aspects of your functioning/quality of life.  

0 - No affect	1 - Slightly affect	2 - Moderately affect	3- Drastically affect		
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		
9. Have any other family members had the same or similar problem/concerns?  Yes  No
10. How aware of this are you during the day? 0 1 2 3 at night? 0 1 2 3
11. Is there any time or activity during which you forget about this symptom/concern? \_\_\_\_\_
12. Why do you think this has happened to you? \_\_\_\_\_
13. Are you doing anything different because of this symptom/concern? \_\_\_\_\_
14. 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'm 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? \_\_\_\_\_

## Medications and Chemical Stresses

- Nerve medication (antidepressants/anxiety/etc)
- Pain medication ( OTC / Prescription )
- Muscle relaxant
- Blood Pressure medication
- Insulin
- Stimulants
- Tranquilizers
- Others \_\_\_\_\_
- I work in an environment with chemicals
- I live or work in a polluted environment
- I eat organic and/or take nutritional supplements  
Which supplements: \_\_\_\_\_

## Emotional Stresses

- past/present
- Recent death in the family
  - Divorce / Separation
  - Serious health problem in the family
  - Stressful work environment
  - Rapid change in life situation
  - Mental, physical or sexual abuse
  - Legal or financial problems
  - Recent move (home/ school / other)
  - Other \_\_\_\_\_

## Physical Traumas and Health History

1. Have you ever injured your spine?  Yes  No

Explain: \_\_\_\_\_

2. Please check any that apply past or present:

- |                                       |   |  |   |
|---------------------------------------|---|--|---|
| <input type="checkbox"/> Surgery      | <input type="checkbox"/> Headaches          | <input type="checkbox"/> Kidney problems | <input type="checkbox"/> Digestive problems |
| <input type="checkbox"/> Fractures    | <input type="checkbox"/> Anxiety/Depression | <input type="checkbox"/> Cancer          | <input type="checkbox"/> Blood Pressure pbs |
| <input type="checkbox"/> Car accident | <input type="checkbox"/> Vertigo            | <input type="checkbox"/> Sleep problems  | <input type="checkbox"/> Breathing problems |
| <input type="checkbox"/> Bad fall     | <input type="checkbox"/> Diabetes           | <input type="checkbox"/> Liver problems  | <input type="checkbox"/> Thyroid problems   |
| <input type="checkbox"/> Arthritis    | <input type="checkbox"/> Heart problems     | <input type="checkbox"/> Addiction pbs   | <input type="checkbox"/> Psychological pbs  |
| <input type="checkbox"/> Spinal pain  | <input type="checkbox"/> Sinus problems     | <input type="checkbox"/> Emotional pbs   | <input type="checkbox"/> Other: _____       |

3. Have you had any X-rays, CT scans or MRI images of your spine?  Yes  No

4. Have you ever been adjusted by a chiropractor or had your spine manipulated?  Yes  No

When: \_\_\_\_\_

5. Do you have an exercise, meditation, prayer, nutritional, or dietary program?  Yes  No

Please describe: \_\_\_\_\_

6. When stressed, how do you « center yourself » or « regroup »? \_\_\_\_\_

## 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 questions 1 and 2 answer by Y - yes or N - no:

1. What benefits available through care in this office do you hope to achieve?

- 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 life enjoyment and the ability to make more constructive choices
- e) \_\_\_ Overall improved quality of life

2. For a slightly longer term goal, how to you hope to benefit from care in this office?

- a) \_\_\_ Improvement in my physical capabilities - feeling free in my body
- b) \_\_\_ Increased emotional and mental clarity
- c) \_\_\_ Increased ability to react or respond to stress in positive ways
- d) \_\_\_ Increased life enjoyment and the ability to create my ideal life
- e) \_\_\_ Overall improved quality of life in body, mind and spirit

3. 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.

***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.***