Comprehensive Health Profile

Date:_____

Last Name: _____ First Name:_____ Date of Birth: _____ Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email: _____ Occupation: _____

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

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

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 of my emotional/mental symptoms

____Improvement in my ability to respond to stress

____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, please describe the reason you are consulting our office then skip to History of Physical Stress Section. If yes, please describe: _____

_____

When did it begin? _____ What were the circumstances? _____

_____

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

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; would like you to assists 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 □ 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_____ □ Steps_____
□ On ice_____ □ Out of tree_____ □ Bars at school_____ □ Skiing/Snowboarding_____
□ Knocked unconscious____ □ Used crutches/cane_____ □ Involved in combat_____ □ Physical fight_____
□ Broken Bones/Sprains (please describe:)_____ □ Physical abuse_____
□ Sports Injuries_____ □ Extensive dental work/orthodontia_____ □ Other Falls (please describe):_____
_____
Accidents, near accidents, driver or passenger: (check all that apply, give age & year)
□ Automobile, details: _____
□ Motorcycle_____ □ Bus_____ □ Train_____ □ Bicycle_____ □ Plane_____
□ Other: _____
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 glasses □ Wear bifocals
Comments:_____

Medical Intervention: (check all that apply, give age & year)
□ Hospitalization, *why*?_____
□ Surgery, *why?*_____
□ Physical Therapy, *why*? _____
□ Chemotherapy_____ □ Radiation_____ □ Casts/Collars_____
□ Spinal/neck brace _____ □ Corrective shoes, bars, lifts_____ □ Transfusion_____
□ Spinal tap/infections _____ □ X-Rays _____ □ Organ Removal_____
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 non-prescription drugs □ Smoke □ Consume alcohol/drugs □Don't Know
At birth was your mother: (check all that apply) □ Conscious □ Semi-conscious □ Unconscious
□ Given spinal anesthesia □ 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_____ □ Personal relationship_____ □ Abuse_____
□ Change in job/career_____ □ School_____ □ Divorce/separtion_____
□ Change of lifestyle_____ □ Recreational_____ □ Work related_____
□ Loss of loved one_____ □ Parent's divorce_____ □ Commuting_____
□ Stress of being sick/ill_____ □ Family_____ □ Financial_____

Comments: _____
_____

History of Emotional Stress

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 of 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_____
□ Mediation_____ □ 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 types 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 (check your preference)

□ Visual Communication: mostly show me pictures and diagrams.
□ Verbal Communication: mostly talk to me about the changes I'm making.
□ Kinesthetic Communication: mostly I need to feel or experience it.

I. Physical State

How often do you experience the following symptoms?

	Never	Rarely	Occasionally	Regularly	Constantly
1. Physical Pain (neck/back ache, sore arms/legs, etc.).	1	2	3	4	5
2. Feeling of tension, stiffness or lack of flexibility.	1	2	3	4	5
3. Fatigue or low energy.	1	2	3	4	5
4. Colds and flu.	1	2	3	4	5
5. Headaches (of any kind).	1	2	3	4	5
6. Heartburn or indigestion.	1	2	3	4	5
7. Nausea or constipation.	1	2	3	4	5
8. Menstrual discomfort.	1	2	3	4	5
8. Allergies or skin rashes.	1	2	3	4	5
9. Dizziness or light-headedness.	1	2	3	4	5
10. Accidents or near accidents or falling or tripping.	1	2	3	4	5
11. Ease of recovery from injury.	1	2	3	4	5
12. Restricted or shallow breathing.	1	2	3	4	5

II. Mental/Emotional State

Rate the following questions with respect to frequency:

	Never	Rarely	Occasionally	Regularly	Constantly
1. If pain is present, how distressed are you about it?	1	2	3	4	5
2. Presence of negative or critical feelings about yourself.	1	2	3	4	5
3. Experience of moodiness, temper or anger outbursts.	1	2	3	4	5
4. Experience of depression or lack of interest.	1	2	3	4	5
5. Over reacting to life's stresses.	1	2	3	4	5
6. Being overly worried about small things.	1	2	3	4	5
7. Experience of vague fears or anxiety.	1	2	3	4	5
8. Difficulty thinking or concentrating or indecisiveness.	1	2	3	4	5
9. Difficulty falling or staying asleep.	1	2	3	4	5
10. Experience of recurring thoughts or dreams.	1	2	3	4	5

III. Stress Evaluation

Evaluate your stress relative to the following:

	None	Slight	Moderate	Considerable	Extensive
1. Family.	1	2	3	4	5
2. Significant Other.	1	2	3	4	5
3. Physical Health.	1	2	3	4	5
4. Finances.	1	2	3	4	5
5. Sex Life.	1	2	3	4	5
6. Work or School.	1	2	3	4	5
7. Coping with daily problems.	1	2	3	4	5

IV. Life Enjoyment

Rate the following statements with respect to frequency:

	Never	Rarely	Occasionally	Regularly	Constantly
1. Openness to guidance from your "inner voice/feelings".	1	2	3	4	5
2. Experience of peace, relaxation, ease or well-being.	1	2	3	4	5
3. Presence of positive feelings about yourself.	1	2	3	4	5
4. Interest in maintaining a healthy lifestyle (e.g., diet, fitness, etc.).	1	2	3	4	5
5. Feeling of being open, aware and connected when relating to others	1	2	3	4	5
6. Level of confidence in your ability to deal with adversity.	1	2	3	4	5
7. Level of compassion for and acceptance of others.	1	2	3	4	5
8. Experience feelings of joy or happiness.	1	2	3	4	5
9. Experiencing gratitude.	1	2	3	4	5
10. Level of satisfaction with your sex life.	1	2	3	4	5
11. Satisfaction with the level of recreation in your life.	1	2	3	4	5
12. Time devoted to things you enjoy.	1	2	3	4	5

V. Overall Quality of Life

Evaluate your feelings relative to your quality of life:

	Unhappy	Mostly Dissatisfied	Mixed	Mostly Satisfied	Delighted
1. Your personal life.	1	2	3	4	5
2. Your wife/husband or "significant other".	1	2	3	4	5
3. Your romantic life.	1	2	3	4	5
4. Your job.	1	2	3	4	5
5. Your co-workers.	1	2	3	4	5
6. The actual work you do.	1	2	3	4	5
7. The handling of problems in your life.	1	2	3	4	5
8. What you are actually accomplishing in your life.	1	2	3	4	5
9. Your physical appearance - the way you look.	1	2	3	4	5
10. Your ability to adapt to change in your life.	1	2	3	4	5
11. Overall contentment with your life.	1	2	3	4	5