



Confidential Health Profile

Thank You for Printing Clearly

Dear Practice Member:

Today's Date: ____/____/____

Please complete this questionnaire. Your answers will help us determine how best to serve you. THANK YOU.

Name _____ LAST FIRST MIDDLE Age ____ Sex M F Date of Birth _____

Address _____ City _____ State ____ Zip Code _____

Phone: Hm _____ Wk _____ Cell _____ E-mail _____

Occupation _____ Marital Status S M W D Significant Other # of Children: _____

Emergency contact: Name and Phone #: _____

Insurance: _____ Social Security # (for insurance): _____

Who referred you to our office and Network Chiropractic Care? _____

YOUR HEALTH CONCERN OR SYMPTOM

Do you currently have any health concerns? Yes No If yes, please describe _____

When did this situation or concern begin? _____ Have you experienced this concern in the past? _____

Have you done anything about this concern or gotten advice or treatment for it? Yes No If yes, when? ____

Who did you see? _____ What were you told? _____ What was done? _____

What was different about **YOU**, after this experience? _____

Is there any time, or activity you can be involved with; when you **almost totally forget about** this condition, symptom, or concern? _____

Is there any time of day or an activity, which makes you **more aware** of it? _____

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

If this condition or symptom were to go away tomorrow, what would be different about your life? _____

What are you **doing in your life now** that is different than if you did not have this condition/symptom? _____

Since this happened...have you changed any habits? _____

How do you feel about your current condition? (Please choose **ONE** that **BEST** describes how you feel)

- 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 further enhance my wellness.

Please *circle* the level that this health concern(s) affects the following aspects of your daily functioning/quality of life.

0- It does not affect me 1- It slightly affects me 2- It moderately affects me 3- It drastically affects 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
Overall Concern about Symptom or Condition			0 1 2 3	Concern about Health	0 1 2 3

CHIROPRACTIC HISTORY

Have you received chiropractic care in the past? Yes No If yes, Dr's Name: _____
How often did you receive adjustments? _____ For how long? _____ Date of your last adjustment? _____
If you stopped going, why? _____
Do you know what type of adjustments or what technique(s) or methods she/he used? _____
Were you pleased with her/his service? Yes No Why? _____
Does your immediate family receive chiropractic adjustments? _____

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Have you had, or do you receive the following vehicles towards growth and development? If yes, please mark:  
Acupuncture     Massage/Bodywork     Osteopathy/Cranial Work     Meditation   
Psychotherapy     Exercise/Movement     SRI     Yoga/Tai Chi     Other \_\_\_\_\_

### GENERAL PHYSICAL HISTORY

Have you ever injured your spine (neck, head, back, hips)?  Yes  No  
Date of most *significant* injury: \_\_\_\_\_ Describe: \_\_\_\_\_  
Date of most *recent* injury: \_\_\_\_\_ Describe: \_\_\_\_\_  
Have you ever been in an Auto Accident?  Past Yr     Past 5 Yrs     Over 5 Yrs     Never  
Describe: \_\_\_\_\_  
Have you had any other injuries (job, sports, etc.)?  Past Yr     Past 5 Yrs     Over 5 Yrs     Never  
Describe: \_\_\_\_\_  
Have you had spinal x-rays, CAT scans or MRI's of your spine (head, neck, back or hips)? If yes, when? \_\_\_\_\_  
What were you told about them? \_\_\_\_\_ Where are these films now? \_\_\_\_\_  
Have you had any surgeries? Describe: \_\_\_\_\_  
Have you broken any bones or significantly sprained a part of your body? Describe: \_\_\_\_\_  
Have you ever been hospitalized?  Past Yr     Past 5 Yrs     Over 5 Yrs     Never  
Describe: \_\_\_\_\_  
Are you aware if your birth was?  Traumatic     Breech     "C" Section     Prolonged     Cord around Neck  
Other Comments: \_\_\_\_\_

Do you exercise regularly?  Yes  No    If yes, what kind? \_\_\_\_\_

### MEDICATIONS, DIET, AND CHEMICAL EXPOSURES

Please list **all medications** you have taken in the **past 60 days**, and the **reasons** you have taken them, (prescription *and* non-prescription): \_\_\_\_\_

In the **past**, have you taken **other medications** for a period of more than 3 months?  Yes  No

Please list **medications** and **reason** for taking them: \_\_\_\_\_

Do you or did you work with any chemicals, fumes, dust, powder, smoke, or any other toxic chemicals for prolonged periods?  Yes  No If yes, please explain: \_\_\_\_\_

Do you have any allergies? Describe: \_\_\_\_\_

Are you on a special diet?  Yes  No If yes, what kind? \_\_\_\_\_

How would you describe your general daily eating habits? \_\_\_\_\_

How often do you consume the following products?  Artificial Sweeteners (Nutrasweet, Equal, Aspartame) **Y N**

Smoking: Amount/Day: \_\_\_\_\_  Coffee: Cups/Day: \_\_\_\_\_ Refined Sugar – Candy/Pastries/etc:

Alcohol: Drinks/Week: \_\_\_\_\_  Soda: # / Day: \_\_\_\_\_  a lot  moderate  minimal

## STRESS SURVEY

Please grade and CIRCLE your Past and Present Overall Life Stresses using the following scale:

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

|                                         | <b>PAST</b> |          |          |          | <b>PRESENT</b> |          |          |          |                                                                                                                                                                                                                                                     |
|-----------------------------------------|-------------|----------|----------|----------|----------------|----------|----------|----------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Overall Physical Stress/Trauma</b>   | <b>0</b>    | <b>1</b> | <b>2</b> | <b>3</b> | <b>0</b>       | <b>1</b> | <b>2</b> | <b>3</b> | <i>Includes: falls, accidents, injuries, impacts, postural stress, difficult birth, physical abuse, etc.</i>                                                                                                                                        |
| <b>Overall Emotional/ Mental Stress</b> | <b>0</b>    | <b>1</b> | <b>2</b> | <b>3</b> | <b>0</b>       | <b>1</b> | <b>2</b> | <b>3</b> | <i>Includes: loss of loved ones, legal concerns, work related stress, financial concerns, stress of being ill, rapid change in life situation, change in home/school/job, relationship stress, separation/divorce, mental/emotional abuse, etc.</i> |
| <b>Overall Chemical Stress</b>          | <b>0</b>    | <b>1</b> | <b>2</b> | <b>3</b> | <b>0</b>       | <b>1</b> | <b>2</b> | <b>3</b> | <i>Includes: drugs, smoke, fumes, alcohol, caffeine, allergies, chemical exposure, food additives, anesthesia, perfumes/cognes, etc.</i>                                                                                                            |

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

## YOUR SPECIFIC NEEDS AND HOPES FOR HELP IN THIS OFFICE

In a published study of over 2,800 patients in Network Spinal Analysis Care, conducted at the University of California, Irvine Medical College; patients reported an overall improvement in *all* of the categories of health and wellness listed below. How do you hope to benefit from care in this office?

**0 - Does Not Apply    1 - Not So Important To Me    2 - Important To Me    3 - Very Important To Me**

- \_\_\_ Improvement of my **Physical Symptoms**.
- \_\_\_ Improvement of **Emotional/Mental Symptoms**.
- \_\_\_ Improvement of my **Ability to React or Respond to Stress**.
- \_\_\_ Improvement in **Enjoyment of Life** and the ability to make **Healthier, more Constructive Choices**
- \_\_\_ Overall improvement in **Quality of Life**.

Is there anything else which may help us to better understand you, your history, or your needs that have not been addressed in this survey? Please explain: \_\_\_\_\_

What do you hope to receive from Network Care in this office? \_\_\_\_\_

How will you know your expectations have been met? \_\_\_\_\_

What would motivate you to tell others about the care you receive in this office, and to encourage others to be under Network Care? \_\_\_\_\_

*Thank you for choosing our Chiropractic Office. We are looking forward to helping you develop a healthy spine and nervous system. We are excited about assisting you on your journey to greater health and wellness.*