COMPREHENSIVE HEALTH PROFILE

Last Name:_____ **First Name:**_____ **Date:**_____

Address:_____ **City:**_____ **State:** _____ **Zip Code:**_____

Date of Birth:_____ **Occupation:**_____ **Marital Status: S M P D W**

Best Phone H C W:_____ **Alternate Phone H C W:**_____

Email:_____ **Who referred you to our office:**_____

Please complete this personal survey history survey, as it will provide your Practitioner with important information to better understand your history, your present and longer term needs, and any compromise to your wellness or health related to the quality of life that you may now be experiencing.

Part I : Your Health Concerns or Symptoms and How They May Affect Your Life

1. What would you like to receive from this office? _____
_____
2. Do you have any current health or spinal concerns? If so, please describe: _____
_____
3. When did this situation begin? _____
4. Have you done anything about this concern or gotten any advice or treatment for it? ❑ Yes ❑ No

   If yes, what were you told? _____
5. What was done? _____
6. Did it seem to work? _____
7. What was different about ***you*** after treatment? _____
8. What was different about ***your condition or symptom*** after treatment? _____
_____
9. What was different about ***your concern about the condition or symptom*** after treatment? _____
_____
10. Please grade the level to which this concern(s) affects these aspects of your functioning/quality of life:

0 - It does not seem to affect me. **2 - It seems to moderately affect me.**
1 - It seems to slightly affect me. **3 - It seems to drastically affect me.**

Affect on work	0 1 2 3	Affect on recreation/exercise	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 family life	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	0 1 2 3

Comments: _____

Have any other family members had the same or similar concerns? ❑ Yes ❑ No

a) What did he/she do about them? _____
b) Did it seem to work? _____

11. How aware are you of this during the day? 0 1 2 3 at night? 0 1 2 3
12. Is there any time, or activity you can be involved with when you totally or almost totally forget about this condition, symptom, or concern about this? _____
_____

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

14. Why do you think this happened or continues to happen to you?_____
_____

15. Do you think this is the sole cause? ❑ Yes ❑ No

If no, what else is involved? _____

16. If this condition or were to go away tomorrow, what else would be different in your life? _____

_____

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

_____

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

19. Which best describes your current feeling about yourself and your situation? (Please circle the letter that best applies)

a) I feel helpless, like little or nothing works.

b) This is terrible, really bad, I am 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 assistance in my healing.

e) Anything else? _____

20. Please grade the following on a scale from 0 to 3: **0 - not at all 1 - slight 2 - moderate 3 - extreme**

a) Currently, how inconvenient is your situation, condition, or symptom? 0 1 2 3

b) How inconvenient was it in the past? 0 1 2 3

Part II: Health/Trauma/Medical/Chiropractic and Healing History:

1. Have you **ever** injured your spine (neck, head, back, hips)? ❑ Yes ❑ No

a) Date of **most significant** injury: _____

b) What happened? _____

c) Date of **most recent** injury: _____

d) What happened? _____

2. Please list medications (prescription and non prescription) you have taken within the past 60 days: _____

_____

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

a) What did you take? _____

b) What was the reason for taking this medication? _____

4. Have you had any spinal x-rays, CAT scans, or MRI imaging of your spine (neck, head, back, hips)? ❑ Yes ❑ No

a) When? _____

b) What were you told about them? _____

5. Have you had any surgeries? ❑ Yes ❑ No

Please explain: _____

6. Have you broken any bones, or significantly sprained any part of your body? ❑ Yes ❑ No

Please explain: _____

7. Please list any herbs, nutritional supplements or natural remedies you take regularly: _____

_____

8. Have you consulted a physician or any other health care provider in the past three months? ❑ Yes ❑ No

Please explain: _____

_____

9. Have you had a work and/or auto related collision related injury? ❑ Yes ❑ No

   If so, please describe: _____

10. Has your spine ever been professionally adjusted? ❑ Yes ❑ No

    a) By whom and when? _____

    b) Why did you go? _____

    c) What did he/she do for you? _____

    d) Were you pleased? ❑ Yes ❑ No

    e) Are you still going? ❑ Yes ❑ No

    f) Does your family receive chiropractic care? ❑ Yes ❑ No

11. Do you consult with a physician or any other health care provider for other than routine evaluations?

    ❑ Yes ❑ No

    a) What is the reason for this visit? _____

    b) When was your last visit? _____

    c) What has been done or suggested? _____

12. **Please Describe your sleep habits:**

    a) **Do you sleep:** ❑ Heavily ❑ Moderately ❑ Lightly

    b) **When you awaken, do you:** ❑ Wake up with difficulty and only come to consciousness after some time

    ❑ Wake up easily and fully alert ❑ Wake up slowly with repeated effort

    c) **Please check the boxes that apply to sleep difficulties:**

    ❑ Falling asleep ❑ Staying asleep ❑ Sleeping with other in the room

    ❑ Sleeping with sound/noise around me ❑ Sleeping with the lights on

    ❑ I need white noise to sleep ❑ I have no difficulty sleeping

13. **Please rate the following on a scale from 5 to 1 with 5 best describing you and 1 least describing you:**

Feeling safe in my life is important to me.	5 4 3 2 1
Constancy or knowing what is going to happen next is important to me.	5 4 3 2 1
I am comfortable expressing my emotions.	5 4 3 2 1
I am easily influenced by the emotions of others.	5 4 3 2 1
My schedule and plans are important to me.	5 4 3 2 1
I find rules, stories, facts, and details easy to deal with.	5 4 3 2 1
I have definite rules about how things should be.	5 4 3 2 1
When something bothers me, it is difficult to let go.	5 4 3 2 1
Being correct is important to me.	5 4 3 2 1
I am easily distracted.	5 4 3 2 1
Having a deeper meaning of life is very important to me.	5 4 3 2 1
I often fear that the tasks that need to be done will not be accomplished on time.	5 4 3 2 1
I often trust that what needs to be done will be done.	5 4 3 2 1
There are times when I become what others expect me to be other than being myself.	5 4 3 2 1
I have a strong sense of who I am and what is important in my life.	5 4 3 2 1

14. When I remember the past, I recall the upside _____% and the downside _____% of the time.

15. Do you have an exercise, meditation, prayer, nutritional, and/or dietary program? ☐ Yes ☐ No

    If yes, please describe: _____

    _____

16. When stressed, how do you “center yourself” or “regroup”? _____

    _____

Part III: Stress Survey:

Please check whether you are experiencing the following stress situations currently, in the past, or both.

	Past			Current		
	Mild	**Moderate**	**Extreme**	**Mild**	**Moderate**	**Extreme**
Childhood stress	❑	❑	❑	❑	❑	❑
School Stress	❑	❑	❑	❑	❑	❑
Play or recreational stress	❑	❑	❑	❑	❑	❑
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	❑	❑	❑	❑	❑	❑

Part IV: Your Specific Needs and Hopes for Help in This Office:

In a published study conducted within the medical college at the University of California, Irvine, over 2.800 people receiving Network Care reported results showing overall improvement in all of the categories of health and wellness below.

Use this scale rating each of the categories in question 1:

a) very important to me b) important to me c) not so important to me d) does not apply

1. What is ***currently*** of interest to you?
   _____ Improvement of my physical symptoms
   _____ Improvement of my emotional/mental symptoms
   _____ Improvement of my ability to react or respond to stress
   _____ Improvement in enjoyment of life and the ability to make constructive choices
   _____ Overall improved quality of life
2. Is there some aspect of your life that very much pleases you, brings you joy, or helps you feel better about yourself? __
   _____
3. Are there any particular factors or elements about your life, experiences, family, work, recreation, past injuries, genetics, dietary programs exercises, outlook, etc. that you feel ***impairs your opportunity for full glowing health?*** _____
   _____
4. Are there any particular factors or elements about your life, experiences, family, work, recreation, past injuries, genetics, dietary programs exercises, outlook, etc. that you feel ***gives you an edge or adds to your wellness?*** _____
   _____
5. When communicating to you about your care: (circle your preference)
   a) Mostly speak with me about the clinical findings and tell me about the changes that I am making.
   b) Mostly show me in written form the clinical findings, and let me see the changes I am making.
   c) Mostly let me get a sense of the clinical work, and help me feel the difference in my body.
6. Is there anything else which may help us understand you, your history, or your professional needs which have not been discussed on this survey? Please explain: _____
   _____
7. What would motivate you to tell others about the care you receive in this office, and encourage others to get in care? _
   _____