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.

LAST FIRST MIDDLE

Name _____ 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

	PAST	PRESENT	
Overall Physical Stress/Trauma	**0 1 2 3**	**0 1 2 3**	*Includes:* falls, accidents, injuries, impacts, postural stress, difficult birth, physical abuse, etc.
Overall Emotional/ Mental Stress	**0 1 2 3**	**0 1 2 3**	*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.
Overall Chemical Stress	**0 1 2 3**	**0 1 2 3**	*Includes:* drugs, smoke, fumes, alcohol, caffeine, allergies, chemical exposure, food additives, anesthesia, perfumes/colognes, etc.

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.