Soulshine Family Wellness Center
Comprehensive Health Profile
Dr. Wendy E. Morris
Email: info@soulshinewellness.com Phone:201-817-5811

Please complete this general health profile, as it will provide us with important information to better understand your history, your present and long term needs, in addition to impacts to your wellness or quality of life.

First Name: _____ **Last Name:** _____
Address: _____ **City:** _____
State: _____ **Zip:** _____
Home phone: _____ **Cell Phone:** _____
Work phone: _____

Which is the best number to reach you at? _____

E-mail: _____ Date of Birth: _____
Occupation: _____

Marital Status: ___ Married ___ Domestic Partner ___ Single ____Divorce ___ Widowed

# of Children: _____

How did you discover our office? _____

If by referral, whom may we thank? _____

Part I: Your Present Health Concerns, Symptoms, and the Way They Affect Your Life

1. **Do you have any current health concerns?** Yes / No
   (a) If yes, please describe: _____
   _____
   _____
2. **When did this situation or health concern begin?** _____
3. **Please grade the level of your awareness of this health concern(s) related to your quality of life.**

   0 – It does not affect me. 1- It slightly affects me. 2 – It moderately affects me.
   3 – It significantly affects me.

Rest / Sleep	0 1 2 3	Social	0 1 2 3
Eating	0 1 2 3	Recreation / Play	0 1 2 3
Sitting	0 1 2 3	Exercise	0 1 2 3
Walking	0 1 2 3	Love Life	0 1 2 3
Work	0 1 2 3		

   (a) How aware of this are you during the day? 0 1 2 3
   (b) How aware of this are you at night? 0 1 2 3

   (c) Is there any time or activity in which you partake, when you almost or totally forget about this health concern?
   _____

(d) Is there any time of day or activity in which you become more aware of this concern?
_____

4. Do the above problems or conditions disrupt...?
Career/Work Family Life Ability to exercise/activity Sleeping Social Life

5. Why do you think that this has happened or continues to happen to you?
_____

(a) Do you think that this is the sole cause? Yes / No

(b) If no, what else is involved? _____

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

(d) What are you doing in your life now that is *different* than if you did not have the health condition?

_____

6. Rate the importance of finding the cause of your problems
(High) 10 9 8 7 6 5 4 3 2 1 (Low)

7. What excuse has prevented you from being healthy and staying healthy?
Money Time Other_____

8. What results do you want for your health?
Reduce Pain Restore health Optimize Health

9. Which best describes your current feeling about yourself and your health concern?
(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 you to assist me in my healing.
(e) Anything else? _____

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

1. Have you consulted a physician or other health care provider <u>about this concern</u> in the past 3 months? Yes / No

(a) Did you consult with a physician for anything other than routine evaluations?
Yes / No

(b) What is / was the reason for visit(s)?
_____

(c) When was your last visit?
_____

(d) What the course of treatment or medical advice?
_____

(e) What was *different* about <u>you</u> after treatment? _____
_____

(f) What was *different* about <u>your condition or symptom</u> after treatment?
_____

2. Has your spine ever been professionally adjusted? Yes / No

(a) If yes, then by whom and when? _____
(b) Why did you go? _____
(c) Are you still going? _____
(d) What did he / she do for you? _____
(e) Were you satisfied with the care you received? _____
(f) Does your family receive chiropractic care? _____

Soulshine Family Wellness Center
Comprehensive Health Profile
Dr. Wendy E. Morris
Email: info@soulshinewellness.com Phone:201-817-5811

3. Have you had any surgery or broken bones? (Please include *all* surgery)

Type	**Date**	**Doctor**
a. _____	_____	_____
b. _____	_____	_____
c. _____	_____	_____

4. Accidents / injuries: auto, work related, sports, etc. (especially those related to your present concerns)

Type	**Date**	**Hospitalized**	
a. _____	_____	_____	Yes / No
b. _____	_____	_____	Yes / No
c. _____	_____	_____	Yes / No

10. Significant childhood injuries (type & age):

_____

6. Have you ever had x-rays taken? Yes / No

(a) If yes, when? _____

(b) Area of Body: _____

(c) Where are these x-rays at present? _____

7. Have you had experience with the following modalities? (Please check all that apply)

Modality	**Duration or Frequency** **Past**	**Present**	**Outcomes**
Massage / Bodywork			
Emotional Therapy / Psychotherapy			
Osteopathy			
Occupational Therapy			
Music/Dance/Light/Sound/Aroma			
Homeopathy / Herbalist			
Ayurvedic Medicine			
Oriental Medicine/Acupuncture			
Nutritional Counseling/Therapy			
Oxygen Therapy/Chelation Therapy			

Rebirthing/Breath work			
Yoga/Movement/Tai Chi/Qi Gong			
Somato-Respiratory Integration			
Exercise/Meditation/Prayer/ Dietary			
Other: _____			

8. Current Medicines

Please list all drugs (prescription & over the counter) that you *currently take or have taken* in the past 6 months.

Name of Medicine	As Treatment For
a. _____	_____
b. _____	_____
c. _____	_____

9. Current Vitamins and Supplements

Please list all vitamins, supplements and homeopathic remedies that you *currently take***.**

Name	As Treatment For
a. _____	_____
b. _____	_____
c. _____	_____

10. Diet

Please circle any dietary selection that is appropriate for you and grade according to the following scale:

D – Consume this daily	M – Consume this monthly
FD – Consume this a few times per day	FM – Consume this a few times per month
W – Consume this weekly	FW – Consume this a few times per week
O – Do not consume this	

___ Alcohol	___ Eggs	___ Raw Vegetables	___ Low Sodium Diet
___ Tobacco	___ Fish	___ Cooked Vegetables	___ Low Cholesterol Diet
___ Coffee	___ Beef	___ Canned Vegetables	___ Weight Control Diet
___ Soda	___ Poultry	___ Fresh Fruit	___ Kosher Diet
___ Fried Foods	___ Dairy	___ Canned /Dried Fruit	___ Whole Grains
___ Refined Sugar	___ Shellfish	___ Soy Protein	___ Raw food Diet
___ Artificial Sweetener	___ Pork	___ Nuts and Legumes	___ Organic Foods

I usually follow a _____ diet. (e.g. vegetarian, macrobiotic, vegan, etc.)

11. When stressed, how do you "center yourself, become grounded, or regroup?"

_____

Soulshine Family Wellness Center
Comprehensive Health Profile
Dr. Wendy E. Morris
Email: info@soulshinewellness.com Phone:201-817-5811

Part III: Stress Survey

As we go through life, we have many good experiences although occasionally, we are faced with stressful situations. Our brain determines when a stressful event is not safe enough to fully experience and this result is stored in our brain and spinal cord. Over a lifetime, these stored stress events can lead to muscle spasm, spinal distortion, diminished breathing, and decreased spinal movement. These stress events result in decreased communication, reduced self-awareness, and disruption of the body's natural rhythms.

Network Spinal Analysis is an approach to wellness that allows increased communication between the brain and the body. Its gentle light force contacts help the nervous system to release spinal and life tensions to promote enhanced wellness.

Neonatal Stress (questions 1 and 2)

In order to understand the source of stress and properly alleviate present tension, please describe the following (circle all that apply):

1. Birth History: Natural Premature Cesarean Epidural Forceps / Vacuum

Other Significant Information: _____

2. Were you vaccinated as a child? Yes / No **As an adult?** Yes / No

3. For each of the following stressors that apply to you, please denote "P" for past or "C" for current.

Stressor	Mild	Moderate	Severe
(a) Childhood Stress			
(b) School Stress			
(c) Play or Recreational Activity (competitive stress)			
(d) Family Relationship Stress			
(e) Personal Relationship Stress			
(f) Move of Home / School / Job			
(g) Physical/Mental/Emotional/Sexual Abuse			
(h) Job-Related Stress			
(i) Commuting Stress			
(j) Loss of Loved One			
(k) Legal or Financial Stress			
(l) Change in Lifestyle			
(m) Change in Career			

(n) Stress of Being Sick			
(o)Other:_____			

How do you rate your physical health?

____Excellent ____Good ____Fair ____Poor ____Getting Better ____Getting Worse

Why: _____

How do you rate your emotional / mental health?

____Excellent ____Good ____Fair ____Poor ____Getting Better ____Getting Worse

Why:_____

How do you rate your chemical exposures? (i.e. drugs, smoke, fumes, chemical sensitivities, food additives)

____Excellent ____Good ____Fair ____Poor ____Getting Better ____Getting Worse

Why:_____

Part IV: Meeting Your Needs and Wellness Planning

Immediate & future benefits sought from network care

Please rate 1 through 4 in terms of your interest.

Numbers may be used more than once as appropriate.

1–Very Important 2–Somewhat Important 3–Slightly Important 4–Not Important

1. Immediate Future

_____	_____	(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 enjoyment of life
_____	_____	(e) Ability to make constructive choices
_____	_____	(f) Overall improved quality of life.

2. Is there some aspect of life (or activity) that very much **pleases you**, brings you joy, or helps you to feel better about yourself.

_____

3. Is there some aspect of life that **impairs** your ability or serves as an obstacle for full glowing health? _____

4. Is there some aspect of life that **enhances** your opportunity toward full glowing health?

_____

Your participation in this process is important to us.

5. When communicating with the doctor, **I would prefer if the doctor would**

____ (a) Mostly **speak with me** about the clinical findings, telling me about the changes I am making;

____ (b) Mostly **show me** in written, visual form the clinical findings, letting me see the changes I am making;

____ (c) Mostly **enable a sense** of the clinical findings, helping me to feel and perceive differences in my body.

6. Is there anything else, not yet discussed, which will assist our understanding of you, your history, or health-related needs.

_____

7. What would motivate or assist you to tell others about the care you receive from Soulshine, encouraging them to get in care at Soulshine as well?

_____

I acknowledge to the best of my ability this information is correct.

_____
Signature

Thank you for choosing Soulshine Family Wellness Center. We look forward to assisting your success in the development of a healthy spine and nervous system, as you continue on your journey towards greater health and wellness!

It's your time to Shine!