Comprehensive Health Profile

Last Name:_____First Name_____Today's Date:_____
Address_____City_____State_____
Zip_____E-mail address:_____Birthdate:_____
Home Phone:_____Work Phone :_____CellPhone:_____

How did you discover this office and the professional services we offer?

_____

Please complete the following health history so that your doctor may better understand your current situation:

Part 1: Your Health Concerns or Symptoms and How They May Affect Your Life

1. Current health concerns: _____
_____
_____
2. When did this situation begin?_____
3. Have you done anything about this situation or concern or obtained any advice or treatment for it? Yes No
4. What was done?_____
5. Did it seem to work?_____
6. What was different about <u>you</u> after the above_____
_____
7. What was different about <u>your condition</u> after the above?_____
_____
8. What was different about <u>your concern about the condition</u> or symptom after treatment?_____
_____

Please use the following scale to grade the level to which this health concern(s) affects these aspects of your quality of life:

0 – It does not seem to affect me 1 - It seems to slightly affect me
2 – It seems to moderately affect me 3 – It seems to drastically affect 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
Concern about particular symptom/condition			0 1 2 3	Concern about health	0 1 2 3

Comments:_____
_____

10. Have any other family members had the same or similar concerns? Yes No
What did he/she do about them?_____
11 Did it seem to work? Yes No _____
12. How aware are you of this during the day? 0 1 2 3 At night? 0 1 2 3
13. Is there any time or activity during which you totally or almost totally forget about this condition, symptom, or concern? _____
14. Is there any time of day or activity that makes you more aware of it? _____
15. Why do you think this has happened or continues to happen to you?_____
_____
16. Do you think this is the sole cause? Yes No _____
17. If no, what else is involved? _____
_____
18. If this condition or symptom were to go away tomorrow, what would be different about your life?
_____
19. What are you doing in your life now that is different than if you did not have this condition/symptom?
_____
20. What would you like to accomplish with your care in this office? _____
_____

21. Since this happened, have you changed any habits?_____
    Touched or held any parts of your body more or differently?_____

22. Which best describes your current feeling about yourself and your situation?
    a) I feel helpless, like little or nothing works.
    b) This is terrible, I'm scared and I hope you can fix it for me.
    c) I feel stuck and I 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? _____

23. Please grade the following on a scale of 0 to 3: (0 - none 1 - slight 2 - moderate 3 - extreme)

    Currently, how inconvenient is your situation, condition or symptom? 0 1 2 3
    How inconvenient was it in the past? 0 1 2 3

Part 2: Health/Trauma/Medical/Chiropractic and Healing History

1. Have you ever injured your spine (neck, head, back, hips)?
   Date of your most significant injury _____
   What happened? _____
   Date of most recent injury _____
   What happened? _____
   Other injuries and dates _____
   _____

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
   Please list: _____
   What was the reason for this medication?_____

4. Have you had any spinal x-rays, CAT scans or MRI's of your spine, (neck, back, or hips) or head? _____
   When? _____

5. What were you told about them? _____

6. Where are these films now? _____

7. Have you had any surgeries? Yes No Please explain _____
   _____

8. Have you broken any bones, or significantly sprained part of your body? Yes No
   Please explain _____

9. Please list any nutritional supplements or natural remedies you take regularly_____
   _____

10. Have you consulted a physician or any other health care provider in the past three months? Yes No
    Please explain:_____

11. Has your spine ever been professionally adjusted? Yes No

    By whom and when _____
    Why? _____
    What did he/she do for you? _____
    Are you still seeing this practitioner? Yes No Were you pleased with the results? Yes No

12. Does your family receive Chiropractic care? Yes No Would you like them to? Yes No

13. Do you consult with a physician for other than routine evaluations? Yes No
14. What is/was the reason for the visit(s)? _____
_____

15. When was your last visit? _____

16. What was done or suggested? _____

17. Have you had experience with the following modalities? If so, please describe when, for how long, and what the results were:

Massage/bodywork _____

Emotional therapy/Psychotherapy_____

Osteopathy _____

Physiotherapy/Occupational therapy _____

Music/Dance/Sound/Light/Aromatherapy _____

Homeopathy _____

Ayurveda _____

Oriental Medicine/Acupuncture/Acupressure _____

Nutritional/Herbal Counseling _____

Oxygen therapy/Chelation therapy _____

Rebirthing/Breathwork _____

Yoga/Movement/Dance/Tai Chi/Chi gung _____

Somato-Respiratory Integration: _____

Other: _____

17. Do you have an exercise, meditation, prayer, or nutritional program? Please describe _____
_____

18. When stressed, how do you "center yourself" or regroup""? _____
_____

Part 3 Stress Survey : Please grade the following stresses in order of increasing intensity and circle any that apply:

(0 – no awareness of stress 1 – slightly stressful 2 – moderately stressful 3 - extremely stressful)

1) **Overall Physical Stress/Trauma**: Includes falls, accidents, injuries, repeated postural stress impacts, difficult birth, traction, physical abuse. 0 1 2 3

2) **Overall Emotional/Mental Stress:** Includes loss of loved ones, rapid change in life situation, mental/emotional/sexual abuse, legal concerns, financial concerns, move from home/school, separation/divorce, stress of being ill etc. 0 1 2 3

3) **Overall Chemical Stress:** Includes drugs, smoke, fumes, food additives, medication, vaccines, amalgam fillings, etc. 0 1 2 3

Is there anything else that we haven't covered that you'd like to share with me?

_____
_____
_____