

# Comprehensive Health Profile

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Email: \_\_\_\_\_ Occupation: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

How did you discover our office? \_\_\_\_\_

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

Have you had your spine or nervous system examined professionally? Y N By whom? \_\_\_\_\_

What type of care was given? \_\_\_\_\_

Where you pleased? Y N \_\_\_\_\_

**This is an opportunity to improve the quality of your life. You may have health concerns and you may have none. Please Note that either way, we will work with you to deepen your experience of wellness.**

1) Do you have any health concerns? If so please describe. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2) Do you experience pain? Y N If yes, on a scale of 0 - 10 (10 being high pain) what level of pain do you experience?  
\_\_\_\_\_

3) Please grade and circle the level to which this health concern affects you .  
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  
Concern about symptom 0 1 2 3 Concern about Health 0 1 2 3 Concern about Well-Being 0 1 2 3

4) When did this situation or concern begin? \_\_\_\_\_

5) Have you done anything or sought treatment? Y N If yes, what where you told? \_\_\_\_\_  
\_\_\_\_\_

6) What was done? \_\_\_\_\_

7) Did it seem to work? \_\_\_\_\_

8) What was different about **YOU**, after treatment? \_\_\_\_\_

9) What was different about your **CONDITION** or **SYMPTOM** after treatment? \_\_\_\_\_

10) Why do you think this has happened or continues to happen to you? \_\_\_\_\_  
\_\_\_\_\_

Do you think this is the sole cause? Y N \_\_\_\_\_

If no, what else is involved? \_\_\_\_\_

- 11) How do you feel about your current condition? (Choose all that apply.)
- 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 am looking for something to help me enhance the quality of my life and further my well-being.
  - I don't know how I feel.

# How Stressed Are you?

## 1) Please grade your past and current stress using the following scale:

0 - No Stress 1 - Slightly Stressful 2 - Moderately Stressful 3 - Extremely Stressful

A) **Overall Physical Stress & Trauma:** Includes: falls, accidents, injuries, postural stress, impacts, falls, physical abuse, loss of consciousness, broken/fractured bones ...  
0 1 2 3

B) **Overall Emotional/Mental Stress:** Includes: loss of loved ones, rapid change in life situations, abuse, move of home/school, legal concerns, financial concerns, divorce, relationships ...  
0 1 2 3

C) **Overall Chemical Stress:** Includes: prescription and non-prescription drugs, smoke, alcohol, caffeine, fumes, food additives, anesthesia from surgery ...  
0 1 2 3

2) When Stressed how do you center yourself and re-group? \_\_\_\_\_

3) Do you have an exercise, meditation, prayer or nutritional program? \_\_\_\_\_

## Physical History

**Birth Stress:** Information about your birth history.

1) Did your mother have a difficult pregnancy with you? Y N \_\_\_\_\_

2) Did your mother have any falls, accidents or physical injuries during pregnancy? Y N \_\_\_\_\_

3) Was your birth traumatic? \_\_\_\_\_

4) Was you birth: \_\_\_Drug Induced \_\_\_Forceps or suction \_\_\_Prolonged \_\_\_Natural  
\_\_\_C-Section \_\_\_Breech \_\_\_Cord around your neck

**General Physical Trauma:**

5) Were you ever knocked unconscious? Y N How/When \_\_\_\_\_

6) Have you ever broken any bones? Y N When/What \_\_\_\_\_

7) Have you significantly sprained/strained a part of your body? Y N When/What \_\_\_\_\_

8) Have you ever had any impacts, falls or jolts that you feel may have injured your spine, head or hips? Y N \_\_\_\_\_

9) Have you served in the military? Y N If yes, were you involved in combat? Y N \_\_\_\_\_

10) Is your day filled with ... (Circle all that apply)

Sitting, Standing, Desk Work, Phone Work, Computer, Driving, Lifting, Manual Labor, Stooping/Bending/Kneeling.

**Sports or Leisure:**

11) Were you or are you active in any sports? Y N Which sports? \_\_\_\_\_

12) Have you been hurt in any of these activities? Y N How/When? \_\_\_\_\_

**Automobile Accidents:**

13) Have you ever been in a car accident? Y N Please List dates and severity. \_\_\_\_\_

14) Have you ever been in a bus, bicycle, motorcycle, train, airplane, moped, boat or other vehicle accident? Please explain. \_\_\_\_\_

**Medical Treatment:**

15) Have you ever been hospitalized? Y N If yes, what was done to you? \_\_\_\_\_

16) Have you had surgery? Y N Explain: \_\_\_\_\_

17) Do you have all your body parts? Y N Explain: \_\_\_\_\_

18) Have you had any spinal X-rays, Cat scans or MRI imaging of your spine or head? Y N \_\_\_\_\_

When & What were you told? \_\_\_\_\_

## Chemical History

- 1) Please list prescription and/or over the counter drugs that you are **currently** taking and why you are taking them. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- 2) Please list any drugs that you have taken regularly in the **past**. \_\_\_\_\_  
\_\_\_\_\_
- 3) Do you or did you have a history of alcohol/drug abuse or heavy use? Y N \_\_\_\_\_  
\_\_\_\_\_
- 4) Do you or did you work or come into contact with any chemical, fume, dust, powder or smoke for prolonged periods?  
Y N Explain: \_\_\_\_\_
- 5) Please indicate the following chemical stressors that you consume:  
I drink \_\_\_\_\_ cups of coffee/day, week, month.      I drink \_\_\_\_\_ glasses of alcohol/day, week, month.  
I drink \_\_\_\_\_ cups of soda/day                              I eat \_\_\_\_\_ candy or pastries/day  
I smoke/chew \_\_\_\_\_ tobacco/day, week, month.      I take \_\_\_\_\_ doses of prescription or over the counter/day, wk, mth.

## Emotional History

- 1) Do you experience emotional/mental stress in the following areas?  
Please indicate if it was in the past and/or if you are dealing with it now.
  - Family Stress: \_\_\_\_\_  
\_\_\_\_\_
  - Work/School Stress: \_\_\_\_\_  
\_\_\_\_\_
  - Loss of a loved one: \_\_\_\_\_  
\_\_\_\_\_
  - Stressful life situation: \_\_\_\_\_  
\_\_\_\_\_
  - Stress of being sick: \_\_\_\_\_  
\_\_\_\_\_
  - Relationship Stress: \_\_\_\_\_  
\_\_\_\_\_
  - Change in lifestyle or vocation: \_\_\_\_\_  
\_\_\_\_\_
  - Abuse (Verbal, physical, emotional, sexual, etc.): \_\_\_\_\_  
\_\_\_\_\_

## Your Specific Needs

- 1) In a published study of health and wellness benefits for patients under Network Care, conducted at the University of California, Irvine Medical College, patients reported an overall improvement in all of the following categories listed below. How do you hope to benefit from care in this office?
  - \_\_\_\_\_ 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 Healthier & More Constructive Choices**.
  - \_\_\_\_\_ Overall improvement in **Quality of Life**.
- 2) Is there anything else that you would wish to share? \_\_\_\_\_  
\_\_\_\_\_