Chiropractic Health Profile

Name:_____ **Today's Date:**_____

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

Home Phone:_____ **Work Phone:**_____ **Cell Phone:**_____

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

How did you hear about our healing center and the services we provide?

_____

Please complete this general health history survey, as it will provide your doctor with important information to better understand your history, your present and longer term needs, and any compromise to your wellness or health related quality of life that you may now be experiencing. ***Please read the entire form before beginning.***

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

1. Do you have any current health concerns? If so please describe.

_____

_____

2. When did this situation or concern begin?_____
3. Have you done anything about this situation or concern or gotten any treatment for it? Yes No
   If yes, what were you told?_____
4. What was done?_____
5. Did it seem to work?_____
6. What was different about you after treatment?_____
7. Please grade the level of which this health concern(s) affects the following aspects of your functioning 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

8. Have any other family members had the same or similar concerns? Yes No
   If yes, what did he/she do about it? _____
   Did it seem to work? _____
9. How aware are you of this during the day? 0 1 2 3 at night? 0 1 2 3
10. Is there any time, or activity you can be involved with when you totally or almost totally forget about this condition, symptom or concern?_____
11. Is there any time or activity which makes you aware of it?_____
12. Why do you think this has happened or continues to happen to you?_____

_____

13. Do you think this is the sole cause? Yes No
    If no, what else is involved? _____

_____

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

_____

_____

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

1. Have you ever injured your spine neck head back hip? (Please circle all that apply)
   Date of most significant injury._____
   What happened? _____
   _____
   Date of most recent injury?_____
   What happened?_____
   What position do you sleep in? back side stomach (Please circle all that apply)

2. Please list medications (prescription or 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
   What did you take?_____
4. Have you had any spinal X-Rays, Cat Scans, or MRI imaging of your spine, head, neck, back or hips(Please circle all that apply)? Yes No
   What were you told about them? _____
   Where are these films now? _____
5. Have you had any surgeries? Yes No
   Please explain: _____
6. Have you broken any bones, or significantly sprained 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 3 months? Yes No
   Who:_____
9. Has your spine ever been professionally adjusted? Yes No
   By whom:_____
   Why did you go? _____
   Are you still going? Yes No
   What did he/she do for you?_____
   _____
   Were you pleased? Yes No
   Does your family receive chiropractic care? Yes No
10. Do you consult with your physician for other routine evaluations? Yes No
    What is/was the reason for the visit? _____
    When was your last visit? _____
    What was done or suggested? _____
    _____
11. Do you have an exercise, meditation, prayer, nutritional or dietary program? Yes No
    Please explain: _____
12. When stressed, how do you center yourself or regroup? _____

Part III: Stress Survey

Please grade the following stresses in order of increasing intensity.

0 – no awareness of any stress **1 – slightly stressful situation**
2 – moderately stressful situation **3 – extremely stressful situation**

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 or emotional or sexual abuse, legal concerns, move of home/school, separation or divorce etc. In relationship, being ill
   0 1 2 3
3. **Overall Chemical Stress**: Includes drugs, smoke, fumes, food additives etc.
   0 1 2 3
4. Have you had a work/vehicular accident related injury? Yes No
   Please Describe:_____

Part IV: Your Specific Needs And Hopes For Help In This Office

Use this scale for questions 1 and 2:

A) Very important to me **B) Important to me**
C) Not so important to me **D) Does not apply**

1. Please choose which of the following five choices is currently of most interest to you. In a published study of over 2,800 patients in Network Care, conducted within the Medical College at the University of California-Irvine, 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?

a) _____ Improvement of my physical symptoms
b) _____ Improvement of my emotional/mental symptoms
c) _____ Improvement of my ability to react or respond to stress
d) _____ Improvement in enjoyment of life and the ability to make constructive choices
e) _____ Overall improved quality of life

2. For a slightly longer term goal how do you hope to benefit from care in this office?

a) _____Improvement of my physical symptoms.
b) _____Improvement of my emotional/mental symptoms
c) _____Improvement of my ability to react or respond to stress
d) _____Improvement of my enjoyment of life and the ability to make constructive choices
e) _____Overall improved quality of life

3. Is there some aspect of your life that very much pleases you, brings you joy, or helps you feel better about yourself?

_____

4. Are there any particular factors or elements about your life, experiences, family, work, recreation, past injuries, genetics, dietary program, exercise, outlook, etc. that you feel impair your opportunity for full glowing health?_____

_____

5. Are there any particular factors or elements about your life, experiences, family, work, recreation, past injuries, genetics, dietary program, exercises, outlook, etc. that you feel give you an edge to your health?_____

_____

Your answers to the following questions will help us to help you better participate in a program of care specifically focused on your spine, your nervous system, and your health and wellness.

6. When communicating to you about your spine, nervous system, health, and wellness: (please circle your preference)
    a) Mostly speak about the clinical findings and tell me about the changes I'm making.
    b) Mostly show me in written form the clinical findings, and let me see the changes that I am making.
    c) Mostly let me get a sense of the clinical work, help me feel the difference in my body.
7. Is there anything else which may help us to understand you, your history, or your professional needs which have not been discussed on this survey? Please explain:_____

_____

8. What would motivate you to tell others about the care you receive in this office, and encourage others to get care?_____

_____

Thank you for choosing our Chiropractic Office. We look forward to helping you to be successful in your ability to develop a healthy spine and nervous system. We are excited about the possibility of assisting you as you continue on your journey towards greater health and wellness.