



Comprehensive Health Profile

Date _____

Name _____ Address _____

City _____ State _____ Zip _____ Occupation _____

Home Phone _____ Cell Phone _____ Email _____

Date of Birth _____ Age _____ Marital Status S M W D

Names & Ages of your Children _____

Who referred you to our office? _____

PLEASE ANSWER THE FOLLOWING QUESTIONS ABOUT YOUR PERSONAL HISTORY

Do you currently have any health concerns? Yes No Please Describe: _____

Have you done anything or sought treatment for this situation or concern? Yes No If yes, what were told? _____

What was done? _____ Did it seem to work? _____

Why do you think this has happened (or continues) to happen to you? _____

Have you received any type of chiropractic care in the past? Yes No Were you pleased with their care? Yes No

What do you hope to receive from Network Care in this office? _____

Do you have any X-rays, MRI's or CT scans of your head, spine or pelvis? What were you told about them? _____

Please check how your health concerns affect your ability to function and your quality of life.

Affect on your Life

- Lose patience with people
- Restricted activity
- Hinder ability to exercise or participate in sports
- Exhaustion at the end of the day

Affect on Work

- Decision Making
- Poor Attitude
- Decreased Productivity

Does this cause

- Moodiness
- Irritability
- Poor or interrupted sleep
- Restriction of Daily Activities

PHYSICAL HISTORY

GENERAL PHYSICAL TRAUMA:

Were you ever knocked unconscious? Yes No How/When? _____

Have you ever broken any bones? Yes No Which Ones? _____

Have you ever had any impacts, falls, or jolts that you feel specifically may have injured your spine? Yes No

How / When? _____

Do you spend a prolonged period of time with any of the following positional stresses? Sitting Standing Desk Work
 Phone Work Computer Work Driving Lifting Heavy Objects Manual Labor Stooping/Bending/Kneeling
 Playing Musical Instruments

Have you ever been injured in a sporting activity? Yes No Where? _____

AUTOMOBILE ACCIDENTS:

Have you, (even as a passenger, even if you do not think you were hurt), been involved in a car accident, or near collision? Please list approximate *dates* and *severity* (Mild, Moderate, Extreme).

Automobile: _____

Bus, bicycle, motorcycle, train, airplane, moped, or other vehicles: _____

MEDICAL TREATMENT:

Have you ever been hospitalized? Yes No If yes, what was done to you? _____

Have you had surgery? Yes No If yes, what was done to you? _____

Have you ever had: Spinal Tap Spinal Injections Cortisone Injections

CHEMICAL HISTORY

Are you **currently** taking any drug(s) (prescription or over-the-counter)? Please list drug(s), **when** prescribed and **reasons** for taking them _____

In the **past**, did you take other medication regularly? Which Ones / How Long? (if applicable, please include birth control pills)

Do you now, or in the past, have a history of alcohol / drug abuse or heavy use? Yes No

Please describe: _____

Do you or did you work with any chemical, fume, dust, powder, smoke for prolonged periods? Yes No

EMOTIONAL HISTORY

GENERAL EMOTIONAL TRAUMA:

Please check any emotional stress you have encountered and how it has affected you in the past or present.

Potential Spinal Stress/Tension Sources	PAST	PRESENT
Childhood Stress	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Extreme	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Extreme
School Stress	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Extreme	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Extreme
Family Stress	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Extreme	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Extreme
Personal Relationships	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Extreme	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Extreme
Work Stress	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Extreme	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Extreme
Stress of being sick	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Extreme	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Extreme
Loss of Loved One	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Extreme	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Extreme
Abuse (Verbal, Physical, Emotional, Sexual, etc)	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Extreme	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Extreme

LIFESTYLE

Do you take daily? vitamins antioxidants omega-3 fatty acids none

Do you consume? organic meats organic fruits organic vegetables none

How many ounces of water do you drink per day?_____. Is it Tap water Purified / bottled water?

Describe your level of physical activity High Moderate Low

What physical activities do you enjoy? _____

How often do you do these physical activities that you enjoy? _____

What do you do for relaxation? _____

How many hours do you work per week? _____

How many hours of sleep do you get per night? _____

What is your quality of sleep? great good fair poor

Is it easy for you to fall asleep at night? Yes No If No, describe why _____

YOUR SPECIFIC NEEDS AND HOPES FOR HELP IN THIS OFFICE?

In 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 of health and wellness listed below (highlighted in **BOLD**). How do you hope to benefit from care in this office? (use scale below to answer each category)

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

- 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** and the ability to make **Healthier, more Constructive Choices**.
- e) ____ Overall improvement in **Quality of Life**.

Signature

Date

