

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

2 – It seems to moderately affect me

1 – It seems to slightly 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? _____
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.