Comprehensive Health Profile

Date:_____

Last Name:_____ First Name: _____ Date of Birth:_____

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

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

Email:_____ Occupation:_____

Marital Status: S M D W Partner's Name: _____ Do you have children? Y N

Who referred you or how did you hear about our office?_____

What are your reasons for seeking care at our office? Please rank the following:

(4=Very Important to me; 3=Important to me; 2=Not so Important to me: 1=Does not apply)

____Improvement of my physical symptoms ____Improvement in my ability to respond to stress

____Improvement of my emotional/mental symptoms ____Improvement in my enjoyment/quality of life

Your Symptoms and How They May Influence Your Life:

Do you have a current health/life concern or symptom? If yes, please describe: _____

_____

When did it begin? _____ What were the circumstances?_____

Is the reason you are consulting our office the result of an injury at work or an auto accident? **Y N** If so, date of injury? _____

Have you done anything about this concern, or been given any advice or treatment for it? **Y N** If yes, what were you told and by whom?_____

_____

What was done?_____

Did it seem to work? **Y N** What was different about your symptom or concern after treatment?_____

_____

Please grade the level to which the concern/symptom affects the following aspects of your functioning/quality of life

(0=does not seem to affect me; 1=slightly affects me; 2=moderately; 3=extremely)

Work	0 1 2 3	Recreation/Play	0 1 2 3	Rest/Sleep	0 1 2 3
Social Life	0 1 2 3	Walking	0 1 2 3	Sitting	0 1 2 3
Exercise	0 1 2 3	Eating	0 1 2 3	Love Life	0 1 2 3

Comments: _____

Have any other family members had the same or similar concerns? **Y N**

What did he/she do about it? _____Did it seem to work? **Y N**

How aware are you of your symptom/concern during the day? 0 1 2 3 At night? 0 1 2 3

Is there any activity during which you totally, or almost totally, forget about this condition, symptom or concern? _____

Why do you think this is happening, or continues to happen to you?_____

_____

Do you think this is the sole cause? **Y N** If no, what else is involved? _____

_____

Are you doing anything differently in your life because of this symptom/condition/concern? **Y N** If yes, what?_____

If it were to go away tomorrow, what would be different about your life?_____

_____

Since the development of this symptom/concern, have you:

Changed any habits: **Y N** If so, what? _____

Held or touched a part of your body more often or differently? **Y N**

Moaned, cried, or made sounds that you usually do not make? **Y N**

Which best describes your current feeling about yourself and your situation?

___I feel helpless, like little or nothing is working. ___This is terrible, really bad; I hope you can fix it for me.

___I feel stuck. ___I deserve more than this, and would like you to assist me with my healing.

___Other, please describe: _____

HISTORY OF PHYSICAL STRESS

Birth Stress: Were there any problems associated with your mother's pregnancy with you? (check all that apply) ❑Falls/Injury ❑Illness ❑Difficult ❑Don't know Comments:_____
Was your birth: (check all that apply) ❑Traumatic ❑C section ❑Breech ❑Forceps or Suction ❑Cord around neck ❑Prolonged ❑Very Fast ❑Natural ❑Drug induced ❑Home ❑Hospital ❑Birthing Ctr
Comments:_____

General Physical Trauma: Falls: (check all that apply, give age & year) ❑Crib/Carriage_____
❑Steps_____ ❑On ice _____❑Out of Tree _____❑Bars at School_____ ❑Skiing/Snowboarding____
❑Other falls (please describe):_____
❑Knocked unconscious_____❑Used crutches/cane_____ ❑Broken Bones/Sprains (please describe)_____
Involved in ❑Combat_____ ❑Physical fight_____ ❑Physical abuse_____ ❑Sports injuries_____
❑Extensive dental work/orthodontia_____ ❑Other, please describe:_____

Accidents, near accidents, driver or passenger: (check all that apply, give age & year)
❑Automobile, details:_____
❑Motorcycle_____ ❑Bus_____ ❑Train_____ ❑Bicycle_____ ❑Plane_____ ❑Other:_____
❑Comments:_____

Daily Activities: (check all that apply)
❑Sit ❑Stand ❑Walk ❑Desk work ❑Phone work ❑Sports ❑Exercise ❑Computer work
❑Watch TV ❑Driving/commuting ❑Play musical instrument ❑Read for prolonged periods
❑Mechanical work ❑Heavy lifting ❑Wear contracts ❑Wear glasses ❑Wear bifocals
❑Comments:_____

Medical Intervention: (check all that apply, give age & year)
❑Hospitalization *why*? _____
❑Surgery *why*? _____
❑Chemotherapy _____ ❑Radiation_____ ❑Casts/Collars_____
❑Spinal/neck brace_____❑Corrective shoes, bars, lifts _____❑Physical therapy_____
❑Spinal tap/injections _____❑X-rays_____ ❑Transfusion _____ ❑Organ Removal _____
❑Comments:_____

Have you or a family member suffered a serious illness?_____
Do you have a family doctor? **Y N** Who?_____
Date of last medical consultation & result:_____
For women: Are you pregnant? **Y N** Date of last monthly period:_____

Have you ever had any of the following diseases or medical problems?

❑**Anemia**	❑**Dizziness**	❑**Menstrual Problems**	❑**Kidney Problems**
❑**Asthma**	❑**Arthritis**	❑**Depression**	❑**Psychiatric Conditions**
❑**Cancer/Chemotherapy**	❑**Diabetes/TB**	❑**Difficulty Breathing**	❑**Fatigue**
❑**Emphysema/Glaucoma**	❑**Epilepsy/Seizures**	❑**Herpes**	❑**Headaches**
❑**Heart Attack/Stroke**	❑**Heart Surgery**	❑**Hepatitis**	❑**Sinus Problems**
❑**Abnormal Bleeding**	❑**HIV/AIDS**	❑ **High/Low Blood Pressure**	❑**Allergies**
❑**Ulcers/Colitis**	❑**Tingling/Numbness**		

How do you grade your overall physical health?
❑Excellent ❑Good ❑Fair ❑Poor ❑Getting Better ❑Getting Worse

HISTORY OF CHEMICAL STRESS

Birth Stress: During your mother's pregnancy, did she: (check all that apply)
❑Use prescription drugs ❑Use nonprescription drugs ❑Smoke ❑Consume alcohol/drugs ❑Don't know
At birth was your mother: (check all that apply) ❑Conscious ❑Semi-conscious ❑Unconscious ❑Given spinal anesthesia ❑Given chemicals to alter or induce labor ❑Don't know

General Chemical Stress: Do you or have you ever taken: (check all that apply) ❑Prescription drugs ❑Over-the-counter drugs ❑Antibiotics ❑Other drugs ❑Tobacco

List all current and past Medications: (include reason and length of time you were on them)_____
_____
Do you or have you worked with or ever been exposed to: ❑Chemicals ❑Fumes ❑Dust ❑Powders/Particles ❑Smoke ❑Other substances_____
Do you consume: ❑Alcohol ❑Coffee/caffeine ❑Processed food ❑Artificial sweeteners ❑Refined sugar ❑Sodas ❑Tap water ❑Describe diet:_____

HISTORY OF EMOTIONAL STRESS

Were you incubated or isolated after birth? **Y N** Were you: ❑Bottle fed ❑Nursed ❑Both
***PAST* General Emotional Trauma**: **(check all that apply and note severity: mild, moderate, extreme)**

❑Childhood_____	❑Personal relationship_____	❑Change of job/career_____
❑School_____	❑Divorce/separation_____	❑Change of lifestyle_____
❑Recreational_____	❑Work related_____	❑Loss of loved one_____
❑Parent's divorce_____	❑Commuting_____	❑Abuse_____
❑Family_____	❑Financial_____	❑Stress of being sick/ill_____

Comments:_____
_____
_____

LIFESTYLE PROFILE

How do you grade your emotional/mental health?
❑Excellent ❑Good ❑Fair ❑Poor ❑Getting Better ❑Getting Worse
How do you grade your overall quality of life?
❑Excellent ❑Good ❑Fair ❑Poor ❑Getting Better ❑Getting Worse

Have you pursued other avenues of growth, healing or personal development? (check all that apply and note who you saw, for how long and if you are still going)

❑Chiropractic_____ ❑Acupuncture_____

❑Massage/Bodywork_____ ❑Homeopathy_____

❑Psychotherapy_____ ❑Ayurvedic Medicine_____

❑Osteopathy_____ ❑Physical Therapy_____

❑Aromatherapy_____ ❑Energy Work_____

❑Rebirthing_____ ❑Sound/Light Therapy_____

What aspects of your life please you, bring you joy, and help you to feel better about yourself?_____

_____

_____

What particular factors or elements about your life experiences, family, work, recreation, past injuries, genetics, dietary programs, exercises, outlook, etc.:

Do you feel impair your opportunity for full glowing health?_____

_____

_____

Do you feel give you an edge or add to your life and health?_____

_____

_____

Which of the following do you practice regularly (check all that apply and how many times per week)

❑Exercise___ ❑Yoga___ ❑Chi Gong/Tai Chi___ ❑Movement/Dance___ ❑Meditation___ ❑Prayer___

List any herbs, nutritional supplements or natural remedies you regularly take:_____

_____

When stressed how do you "center yourself" or "re-group"?_____

_____

Is there anything else you wish to share which may help us better understand you and why you have chosen to come to this office?_____

_____

What type of results would motivate you to tell others about the care you receive in this office, and encourage others to get under care?_____

_____

When communicating with you about your spine, nervous system, health and wellness (circle your preference):

a) Visual Communication – Mostly show me pictures and diagrams.
b) Verbal Communication – Mostly talk to me about the changes I'm making.
c) Kinesthetic Communication – Mostly I need to feel it.

In a published study of over 2,800 patients in Network Care, conducted in the Medical College of 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?

Please rate 0-5 (0=not important to me, 5=very important to me)

0 1 2 3 4 5 Improvement of my physical symptoms
0 1 2 3 4 5 Improvement of my emotional/mental symptoms
0 1 2 3 4 5 Improvement of my ability to handle stress
0 1 2 3 4 5 Improvement in enjoyment of life and the ability to make constructive lifestyle choices.

_____

Thank you for choosing Vitality Wellness Center. We are looking forward to helping you 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.