

Comprehensive Health Profile

Today's Date: _____

Name: _____ Address: _____

City: _____ State: _____ Zip: _____

Occupation: _____ Home Phone: _____ Work Phone: _____

Date of Birth: _____ Age: _____ M _____ F _____ Marital Status: _____ No. of Children: _____

SSN: _____ Insurance: _____

Who referred you to our office? _____

Please complete this general history survey, as it will provide your doctor with important information to understand your history, your present and longer term needs, and any compromise to your wellness or life quality.

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

1. What are you seeking help with? _____

2. When did this situation or concern begin? _____

3. Have you done anything about this situation or concern or gotten any advice or treatment for it? Yes _____ No _____

If yes, what were you told? _____

4. What was done? _____

5. Did it seem to work? _____

6. After treatment was there anything different about you, your condition or your concern about the symptoms/condition? _____

7. Please grade the level to which this health concern(s) affects these aspects of your functioning/quality of life.

0 - It does not seem to affect me. 1 - slightly 2 - moderately 3 - drastically

Effect on work 0 1 2 3 Effect on recreation/play 0 1 2 3 Effect on rest/sleep 0 1 2 3

Effect on social life 0 1 2 3 Effect on walking 0 1 2 3 Effect on sitting 0 1 2 3

Effect on exercise 0 1 2 3 Effect on eating 0 1 2 3 Effect on love life 0 1 2 3

8. How aware of this are you during the day? 0 1 2 3 At night? 0 1 2 3

9. Is there any activity you can be involved with when you totally forget about this condition, symptom or concern? _____

10. Is there any time of day or activity which makes you more aware of it? _____

11. Why do you think this has happened or continues to happen to you? _____

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

13. What other health concerns, conditions or "diagnoses" do you have? _____

14. What are you doing about them? Exercise, drugs, diet change, other? _____

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

1. Have you ever injured your spine (neck, head, back, pelvis)?
 - a) Date of *most significant* injury: _____
 - b) What happened? _____

 - c) Date of *most recent* injury: _____
 - d) What happened? _____

2. Have you had a work/vehicular accident related injury or any injury which may involve a lawsuit or an attorney?
Please describe _____
3. Please list medications (prescription or over the counter) you have taken within the past 60 days: _____

4. In the past, have you taken other medications for a period of more than 3 months? Yes _____ No _____
 - a) What did you take? _____
 - b) What was the reason for taking this medication? _____
5. Have you had any spinal x-rays, CAT scans or MRI imaging of your head, neck, back, pelvis or hips? _____
When? _____
6. What were you told about them? _____
7. Where are these films now? _____

8. Have you had any surgeries? Please provide date & nature of surgeries. _____

9. Have you broken any bones, or significantly sprained part of your body? Yes _____ No _____
Please explain: _____
10. Please list any herbs, nutritional supplements or natural remedies you take regularly. _____

11. Has your spine ever been professionally adjusted? Yes _____ No _____
 - a) By whom and when? _____
 - b) Why did you go? _____
 - c) Are you still going? _____ When was your last visit? _____
 - d) What did he/she do for you? _____
 - e) Were you pleased with the results? Yes _____ No _____
 - f) Does anyone in your family receive chiropractic care? Yes _____ No _____
12. Do you consult with a physician for other than routine evaluations? Yes _____ No _____
 - a) When was your last visit? _____
 - b) What was the reason for the visit(s)? _____
 - c) What was done or suggested? _____
 - d) How did that work? _____
13. Have you had experience with the following health, treatment or healing modalities? If so, please describe when you went, for how long and what the results were.

overall improvement in all of the categories of health and wellness listed below. How do you hope to benefit from care in the office?

- ▶ Improvement of my physical symptoms
- ▶ Improvement of emotional/mental symptoms
- ▶ Improvement of my ability to react or respond to stress
- ▶ Improvement in enjoyment of life and the ability to make constructive choices
- ▶ Overall improved quality of life

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

- ▶ Improvement of my physical symptoms
- ▶ Improvement of emotional/mental symptoms
- ▶ Improvement of my ability to react or respond to stress
- ▶ Improvement in enjoyment of life and the ability to make constructive choices
- ▶ Overall improved quality of life

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

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

Your answers to the following questions will help us to help you to 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: (circle your preference)

- a) Mostly speak with me about the clinical findings and tell me about the changes I am 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 to 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 in care?

*Thank you for choosing **Family Chiropractic & Wellness**. We are looking 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.*