

Comprehensive Health Profile

Date: _____

Last Name: _____ First Name: _____ Date of Birth: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Email: _____ SSN: _____ Occupation: _____
Marital Status: S M D W Spouse's Name: _____ Do you have children? Y N
Who referred you or how did you hear about our office? _____
Do you have insurance you want us to bill for your care? _____

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 no, skip to History of Physical Stress Section. 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 Center

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 contacts 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: _____

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? _____

