Comprehensive Health Profile Date:_____

M F

Last Name:_____First Name:_____DOB:_____
Address:_____City:_____
State:_____Zip:_____Occupation:_____
Married Single Children Y N How old?_____
Contact Phone:_____Email:_____
Height:_____ Weight:_____ Add me to the newsletter/email list: Y N
Referred by:_____ SSN:_____

Your Health Concern or Symptom(s)

1. Do you have a current symptom or health/life concern?_____
_____
2. When did it begin?_____
3. Have your consulted or received treatment for this problem? □ Yes □ No
4. What was done? With what result?_____
5. Did your problem change? □ Yes □No 6. Did you change? □ Yes □ No
7. Have your concerns about this problem changed? □ Yes □ No
8. Please grade the level to which this health concern(s) affects these aspects of your functioning/quality of life.

0 - No affect	**1 - Slightly affect**	**2 - Moderately affect**	**3- Drastically affect**
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
Concern about particular symptom/condition		0 1 2 3	Concern about health	0 1 2 3	

9. Have any other family members had the same or similar problem/concerns? □ Yes □No
10. How aware of this are you during the day? 0 1 2 3 at night? 0 1 2 3
11. Is there any time or activity during which you forget about this symptom/concern?_____
12. Why do you think this has happened to you?_____
13. Are you doing anything different because of this symptom/concern?_____
14. Which best describes your current feeling about yourself and your situation?
    a) I feel helpless, like little or nothing works
    b) This is terrible, really bad; I'm scared and hope you can fix it for me.
    c) I feel stuck and can't help myself right now.
    d) I deserve more than what I have been experiencing and would like you to assist me in my healing.
    e) Anything else?_____

Medications and Chemical Stresses

□ Nerve medication (antidepressants/anxiety/etc)
□ Pain medication (OTC / Prescription)
□ Muscle relaxant
□ Blood Pressure medication
□ Insulin
□ Stimulants
□ Tranquilizers
□ Others_____
□ I work in an environment with chemicals
□ I live or work in a polluted environment
□ I eat organic and/or take nutritional supplements
Which supplements:_____

Emotional Stresses

past/present		
□	□	Recent death in the family
□	□	Divorce / Separation
□	□	Serious health problem in the family
□	□	Stressful work environment
□	□	Rapid change in life situation
□	□	Mental, physical or sexual abuse
□	□	Legal or financial problems
□	□	Recent move (home/ school / other)
□	□	Other_____

Physical Traumas and Health History

1. Have you ever injured your spine? □ Yes □ No
   Explain:_____

2. Please check any that apply past or present:

□ Surgery	□ Headaches	□ Kidney problems	□ Digestive problems
□ Fractures	□ Anxiety/Depression	□ Cancer	□ Blood Pressure pbs
□ Car accident	□ Vertigo	□ Sleep problems	□ Breathing problems
□ Bad fall	□ Diabetes	□ Liver problems	□ Thyroid problems
□ Arthritis	□ Heart problems	□ Addiction pbs	□ Psychological pbs
□ Spinal pain	□ Sinus problems	□ Emotional pbs	□ Other:_____

3. Have you had any X-rays, CT scans or MRI images of your spine? □ Yes □ No
   _____
4. Have you ever been adjusted by a chiropractor or had your spine manipulated? □ Yes □ No
   When:_____
5. Do you have an exercise, meditation, prayer, nutritional, or dietary program? □ Yes □ No
   Please describe:_____
6. When stressed, how do you « center yourself » or « regroup »?_____
   _____

Your Specific Needs and Hopes for Help in This Office:

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. In questions 1 and 2 answer by Y - yes or N - no:

1. What benefits available through care in this office do you hope to achieve?
   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 life enjoyment and the ability to make more constructive choices
   e)____Overall improved quality of life

2. For a slightly longer term goal, how to you hope to benefit from care in this office?
   a)____Improvement in my physical capabilities - feeling free in my body
   b)____Increased emotional and mental clarity
   c)____Increased ability to react or respond to stress in positive ways
   d)____Increased life enjoyment and the ability to create my ideal life
   e)____Overall improved quality of life in body, mind and spirit

3. When communicating to you about your spine, nervous system, health and wellness (circle your preference):
   A) Mostly speak with me about the clinical findings. Tell me about the changes I am making.
   B) Mostly show me in written form the clinical findings. 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.

Thank you for choosing our Network Spinal Analysis™ office. We are looking forward to helping you to become successful in your ability to develop new strategies for a healthy spine, nervous system and life.