Comprehensive Health Profile

Date:	Last Name:	First Name:		Middle Initial:
Address:		City:	State:	Zip:
Home Phone:	Cell Phone:	Work Phone:	Email:	
Birth Date:	Social Security Number:	Referred by:	Gender: M F	
Height:	Weight:	Marital Status: M S D W	Spouse Name:	
Emergency Contact Name:		Emergency Contact Phone Number:	# of Children: Boys: Girls:	

(If patient is a child, please use parent employment information)

Employer: Occupation: Work Address:

Your Health Concerns/Symptoms

1. Do you have any current health concerns? Please describe:
   _____
   _____
2. When did this begin?
   _____
   _____
3. Have you received treatment or advice about this? Yes No
4. If yes, what were you told?
   _____
5. What was done?
   _____
6. Did it seem to work? Yes No
7. What was different about <u>you,</u> after treatment?
   _____
   _____
8. What was different about your condition/symptom after treatment?
   _____
   _____
9. What was different about your concern regarding the condition/symptom after treatment?
   _____
10. Is there any time or activity you can be involved with when you totally or almost totally forget about this condition/symptom or your concern about it? Explain:
    _____
11. Is there any time or activity that makes you more aware of it?
    _____
12. Why do you think this has happened or continues to happen?
    _____
13. Do you think this is the sole cause? Yes No

14. If no, what else is involved?

_____

15. Please define the level that this health concern affects aspects of your life by circling the most applicable number:

	0 = doesn't affect me	1 = affects me slightly	2=moderately affects me	3=drastically affects me
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 the issue:	0	1	2	3
Concern about health:	0	1	2	3
Aware of it during the day:	0	1	2	3
Aware of it at night:	0	1	2	3
How inconvenient is this concern?	0	1	2	3
How inconvenient was it in the past?	0	1	2	3

16. Have any other family members had the same or similar conditions? Yes No

17. What did he/she do about them?

_____

18. Did it seem to work? Yes No

19. If this symptom/condition were to go away tomorrow, what would be different about your life?

_____

_____

20. What are you doing in your life now that is different than if you did not have this symptom/condition?

_____

21. Since this happened, have you:

Changed habits? Yes No

Held or touched part of your body more or differently? Yes No

Moaned, cried, or made sounds that you usually don't make? Yes No

22. Which best describes your current feeling about yourself and your situation? Please circle the most accurate statement:

_____ I feel helpless, like little or nothing works.

_____ This is terrible, really bad, I am scared and hope you can fix it for me.

_____ I feel stuck and can't help myself right now.

_____ I deserve more than what I am experiencing and would like you to assist me in my healing.

_____ Other:

_____

Your Health History

1. Childhood diseases: Measles Mumps Chicken Pox
2. Unusual childhood diseases:

_____

3. Do you smoke? Yes No How many? _____
4. Do you drink coffee? Yes No How much? _____
5. Do you drink alcohol? Yes No How much? _____
6. Do you exercise? Regularly Infrequently Seldom
7. Do you take any drugs? Yes No
   Please list:

   _____

   _____
8. Do you take vitamins/supplements? Yes No
   Please list:

   _____

   _____
9. Are you pregnant? Yes No
10. Last menstruation:

    _____
11. Do you have a pacemaker, insulin pump, or other implanted device?

    _____
12. Have you had any spinal xrays, CAT scans, or MRI imaging of your body? Yes No
    When? _____
13. What were you told about them?

    _____
14. Where are these films now?

    _____
15. Have you had any surgeries? Yes No
16. If yes, please explain:

    _____
17. Have you broken any bones or significantly sprained a part of your body? Yes No
18. If yes, please explain:

    _____
19. Have you consulted a physician or other healthcare provider in the past 3 months?
    Yes No
20. Have you ever had your spine professionally adjusted? Yes No
21. By whom?

    _____
22. When?

    _____
23. Reason for adjustment:

    _____
24. Are you still going? Yes No
25. What did the chiropractor do for you?

    _____
26. Were you pleased with the results? Yes No
27. Does your family receive chiropractic care? Yes No
28. Do you consult with a physician? Yes No
29. If yes, please explain:

    _____

30. When was your last visit to this physician?
_____
_____
31. What was the diagnosis?
_____
32. What was done for/discussed about the diagnosis?
_____
33. Physician's name: _____ Address: _____
Phone: _____

34. Specialty:_____
35. Have you ever had experience with the following healing care? If so, please describe when you started, for how long you participated, and what your results were:

Massage/body
work:_____

Emotional therapy/Psychotherapy:
_____

Osteopathy:
_____

Physiotherapy/occupational therapy:
_____

Music/sound/light/aromatherapy:
_____

Homeopathy/herbalist:
_____

Ayurvedic medicine:
_____

Oriental medicine/acupuncture:
_____

Nutritional counseling/therapy:
_____

Oxygen therapy/chelation therapy:
_____

Rebirthing/breathwork:
_____

Yoga/Movement/Dance/Tai Chi/Chi Gong:
_____

Somato Respiratory Integration:
_____

Other:_____

36. Do you have an exercise, meditation, prayer, nutritional, or dietary program? Yes No

    Please describe:

    _____

    The following questions are specific to women.

37. Do you experience pain/discomfort before, during, or after your menstrual period?
    Yes No
38. Do you experience discomfort during the cycle week, regardless of menstruation or menopause?
    Yes No
39. Have you had surgical removal of any/all reproductive organs, or does your period skip occasionally? Yes No
40. During the cycle week are you (circle any that apply):
    Grouchy Irritable Have crying spells Feel more nervous
41. Other problems:

    _____

Stress Survey

1. Would you say you are under stress? None Some Much Please explain:

   _____

2. When stressed, how do you "center yourself" or "re-group"?

   _____

3. Do you experience undue worry, difficulty in concentrating, forgetfulness, failing memory, etc.?
   Yes No
   If yes, please explain:

   _____

4. Please define the impact the following stresses have on your life by circling the most accurate response:

	0 = does not affect me	1 = affects me slightly	2 = moderately affects me	3 = drastically affects me
Overall physical stress/trauma (includes falls, accidents, injuries, repeated postural stress impacts, difficult birth, traction, physical abuse):	0	1	2	3
Overall emotional/mental stress (includes loss of loved ones, rapid change in life situation, mental/emotional/sexual abuse, legal concerns, financial concerns, stress of being ill):	0	1	2	3
Overall chemical stress (includes drugs, smoke, fumes, food additives, etc.):	0	1	2	3

Your specific needs and hopes for care at Vitality

1. How do you hope to benefit from care in this office? Please answer A = very important to me, B = somewhat important to me, C = not so important to me, or D = does not apply:
   _____ Improvement of my physical symptoms
   _____ Improvement of emotional/mental symptoms
   _____ Improve 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. How do you hope to benefit from care as a long term goal? Please answer A = very important to me, B = somewhat important to me, C = not so important to me, or D = does not apply:
   _____ Improvement of my physical symptoms
   _____ Improvement of emotional/mental symptoms
   _____ Improve 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 pleases you, brings you joy, or helps you to feel better about yourself?
   _____
   _____

4. Are there elements about your life, experiences, family, work, recreation, past injuries, genetics, dietary programs, exercises, etc., that you feel impair your opportunity for full health?
   _____
   _____

5. How would you like to communicate about your health? Please check one:
   _____ Speak with me about clinical findings and tell me about the changes that I am making.
   _____ Show me the clinical findings in written form to show the changes that I am making.
   _____ Let me get a sense of the clinical work and help me to feel the difference in my body.

6. Is there anything else which may help us to understand you, your history, or your needs that have not been discussed in this survey?
   _____

   _____

7. What would motivate you to tell others about the care you receive at Vitality, and encourage others to begin care?
   _____
   _____

8. Is there anything else that you would like us to know about you?
   _____
   _____