

Date: ___/___/___

Comprehensive Health Profile

Gentle Chiropractic Care – Dr. Amanda Andersen (303)691-9970

Name: _____ Address: _____

City: _____ State: _____ Zip: _____ Occupation: _____

Mobile Phone: _____ Home Phone: _____ Business Phone: _____

Email: _____

Date of Birth: _____ Age: _____ Marital Status: S M W D Number of Children: _____

Who referred you to our office and the professional services we offer? _____

Have you received any type of chiropractic care in the past? Yes No Were you pleased with their care? Yes No

If "Yes," why did you discontinue your chiropractic care? _____

PLEASE ANSWER THE FOLLOWING QUESTIONS ABOUT YOUR PERSONAL HISTORY

1) Do you currently have any health concerns and why are you seeking care? Yes No Please Describe: _____

2) Please grade and circle the level to which this health concern(s) affects the following aspects of your functioning/quality of life.

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

Affect on Work 0 1 2 3 Affect on Recreation/Play 0 1 2 3 Affect on Rest/Sleep 0 1 2 3

Affect on Social Life 0 1 2 3 Affect on Walking 0 1 2 3 Affect on Sitting 0 1 2 3

Affect on Exercise 0 1 2 3 Affect on Eating 0 1 2 3 Affect on Love Life 0 1 2 3

Concern about Particular Symptom/Condition 0 1 2 3 Concern about Health/Well-Being 0 1 2 3

3) Have you done anything or sought treatment for this situation or concern? Yes No

If "Yes," what were told? _____

4) What was done? _____ Did it seem to work? _____

5) What was different about YOU after treatment? _____

6) What was different about your CONDITION or SYMPTOM after treatment? _____

7) Why do you think this has happened (or continues) to happen to you? _____

Do you think this is the sole cause? Yes No

If "No," what else is involved? _____

8) How do you feel about your current condition? (Please choose ONE that BEST describes how you feel)

- I feel helpless; nothing works.
- I don't like what I am feeling, and I hope you can fix it.
- I feel this is a pattern that has happened to me before; it is back again.
- I feel there is a message my body is giving me.
- I am looking for assistance in becoming healthier so I can move past my health concern.
- I realize my condition may be a necessary experience in getting to the real problem.
- I don't know how I feel. I am too preoccupied with my present condition.
- I am looking for something to help me enhance my quality of life and further enhance my wellness.

9) What do you hope to receive from Network Care in this office? _____

OVERALL STRESS SURVEY

Please grade your Past/Current Life Stresses using the following scale:

0 – No awareness of any stress 1 – Slightly stressful 2 – Moderately stressful 3 – Extremely stressful

A) Overall Physical Stress/Trauma: (includes: falls, accidents, injuries, repeated postural stress, impacts, difficult birth, physical abuse, loss of consciousness, broken/fractured bones, etc.)
0 1 2 3

B) Overall Emotional/Mental Stress: (includes: loss of loved ones, rapid change in life situations, abuse, move of home/school, legal concerns, financial concerns, divorce, relationships, etc.)
0 1 2 3

C) Overall Chemical Stress: (includes: prescription drugs, smoke, alcohol, caffeine, fumes, food additives, anesthesia from surgery, over-the-counter medications, etc.)
0 1 2 3

PHYSICAL HISTORY

BIRTH STRESS: Information about your birth history:

- 1) Did your mother have a difficult pregnancy with you? Yes No
- 2) Did your mother have any falls, accidents or physical injuries during pregnancy? Yes No
- 3) Was your birth traumatic? Yes No
- 4) Was your birth: Drug induced Forceps or Suction Prolonged
 "C" Section Cord around the neck Breech
 Natural Other: _____
- 5) Describe any other physical or mechanical stress to your mother or you as labor progressed, delivery progressed, or as a newborn:

GENERAL PHYSICAL TRAUMA (include year or age):

- 6) Were you ever knocked unconscious? Yes No How/When? _____
- 7) Have you ever broken any bones? Yes No Which Ones? _____
- 8) Have you ever had any impacts, falls, or jolts that you feel specifically may have injured your spine? Yes No
How / When? _____
- 9) Have you ever injured your head, neck, back or hips? Yes No How/When? _____
- 10) Have you served in the military? Yes No If "Yes," were you involved in combat? Yes No
- 11) On average, how many hours per day do you participate in the following? ___Sitting ___Standing ___Desk Work
___Phone Work ___Computer Work ___Driving ___Lifting Heavy Objects ___Manual Labor ___Stooping/Bending/Kneeling

SPORTS OR LEISURE (include year or age):

- 12) Were you, or are you, active in any sport(s)? Yes No Which One(s)? _____
- 13) Have you been hurt in any of these activities? Yes No Where? _____

AUTOMOBILE ACCIDENTS (include year or age):

- 14) Have you, (even as a passenger, even if you do not think you were hurt), been involved in a car accident, or near collision?
 Yes No Please list approximate dates and severity (Mild, Moderate, Extreme).
Automobile: _____
Bus, bicycle, motorcycle, train, airplane, moped, or other vehicles: _____

MEDICAL TREATMENT (include year or age):

- 15) Have you ever been hospitalized? Yes No If "Yes," what was done to you? _____
- 16) Have you had surgery? Yes No If "Yes," what was done to you? _____
- 17) Do you have all of your body parts? Yes No If "No," please describe: _____
- 18) Have you ever had: Spinal Tap Spinal Injections Physiotherapy Neck Collar Spinal Brace Traction
 Heel Lift X-Ray Treatments Corrective Shoes or Bars Extensive Diagnostic X-Rays
 Acupuncture Chemotherapy Transfusion Body Part in a Cast or Immobilized?

CHEMICAL HISTORY

BIRTH STRESS:

- 1) Was your mother regularly taking any drug immediately prior to, or during her pregnancy with you? Yes No
- 2) Did she use: Alcohol Smoking Other: _____
- 3) Was her labor chemically induced or altered? Yes No
- 4) Was your mother: Conscious Semi-Conscious Unconscious during delivery Under spinal anesthesia during delivery?
- 5) Any other chemical stresses that your mother may have been subject to during pregnancy or labor? _____

GENERAL CHEMICAL TRAUMA

6. Are you now taking any drug(s) (prescription or over-the-counter) regularly? Please list drug(s), when prescribed and reasons for taking them: _____
7. Were you previously taking any medication regularly? Which Ones / How Long? _____
8. Do you now or in the past have a history of alcohol / drug abuse or heavy use? Yes No
Please describe: _____
9. Do you or did you work with any chemical, fume, dust, powder, smoke for prolonged periods Yes No
10. Please indicate how much of the following products you consume:
 Alcohol – Drinks/Week: ____ Coffee – Cups/Day: ____ Tobacco – Amount/Day: _____
 Artificial Sweeteners: Yes No Soda- #/Day: ____ Refined Sugar – Candy/Pastries/Day _____

EMOTIONAL HISTORY

BIRTH STRESS

1. My birth was: At Home In Birthing Center In a Hospital Other _____
2. Were you incubated or isolated after birth? Yes No
3. Were you: Bottle Fed Formula Bottle Fed Mother’s Milk Nursed – How Long? _____ Nursed and Bottle fed

GENERAL EMOTIONAL TRAUMA

4. With each of the following potential spinal stress situations, please indicate the severity either past or current.
(You need only check a box if the stressor was or is present)

Potential Spinal Stress/Tension Sources	PAST	CURRENT
Childhood Stress	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Extreme	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Extreme
School Stress	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Extreme	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Extreme
Family Stress	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Extreme	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Extreme
Personal Relationships	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Extreme	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Extreme
Stress of Being Sick	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Extreme	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Extreme
Work Stress	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Extreme	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Extreme
Stress of Commuting	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Extreme	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Extreme
Loss of Loved One	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Extreme	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Extreme
Change in Lifestyle	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Extreme	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Extreme
Change in Vocation	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Extreme	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Extreme
Abuse (Verbal, Physical, Emotional, Sexual, etc.)	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Extreme	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Extreme

YOUR SPECIFIC NEEDS AND HOPES FOR HELP IN THIS OFFICE

A – Very important to me B – Important to me C – Not so important to me D – Does not apply

1. In a published study of health and wellness benefits for patients under Network Care, conducted at the University of California, Irvine Medical College, patients reported an overall improvement in all of the following categories of health and wellness listed below. How do you hope to benefit from care in this office? (use scale from above to answer each category).
 - 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 enjoyment of Life and the ability to make Healthier, more Constructive Choices
 - e) ___ Overall improvement in Quality of Life
2. Is there anything else you may wish to share which may help us to better understand you, your history, or your professional and personal needs which have not been discussed in this profile? (If necessary, please use the back of this form)
