

# COMPREHENSIVE HEALTH PROFILE

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_  
Prov.: \_\_\_\_\_ Postal Code: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Email: \_\_\_\_\_ Date of Birth (MM/DD/YY): \_\_\_\_\_  
How did you discover our office and the professional services we offer? \_\_\_\_\_

*Please complete this general health history and wellness survey. It will provide your practitioner with important information to better understand your history and long term needs, as well as any wellness or health related quality of life compromise you may now be experiencing.*

## Part I: Your Health Concern or Symptoms and How They May Influence Your Life

1. Do you have a current health/life situation? If so, please describe: \_\_\_\_\_

2. When did this situation/concern/symptom begin? \_\_\_\_\_

3. Have you done anything about this situation/concern, been given advice or treatment for it? Yes\_\_ No\_\_  
If Yes, what were you told? \_\_\_\_\_

4. What was done? \_\_\_\_\_

5. Did it seem to work? \_\_\_\_\_

6. What was different about you after treatment? \_\_\_\_\_

7. What was different about your situation/concern/symptom after treatment? \_\_\_\_\_

8. Has your situation/concern/symptom changed since treatment? \_\_\_\_\_

9. 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 – it seems to slightly affect me**

**2 – it seems to moderately affect me**

**3 – it seems to drastically affect 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 this particular situation 0 1 2 3

Concern about health 0 1 2 3

Comments: \_\_\_\_\_

10. Has any other family member(s) had the same or similar concerns? Yes\_\_ No\_\_

If yes, what did he/she do about them? \_\_\_\_\_

11. Did it seem to work? \_\_\_\_\_

12. How aware of this are you: \_\_\_\_\_ during the day? 0 1 2 3 \_\_\_\_\_ at night? 0 1 2 3

13. Is there any activity during which you totally, or almost totally, forget about this situation/concern/symptom? \_\_\_\_\_

14. Is there any time of day which makes you more/less aware of the above? \_\_\_\_\_

15. Why do you think this has happened or continues to happen to you? \_\_\_\_\_

16. Do you think this is the sole cause? Yes\_\_ No\_\_

17. If no, what else is involved? \_\_\_\_\_

18. If this situation/concern/symptom were to go away tomorrow, what would be different in your life? \_\_\_\_\_

19. Are you doing anything differently because of this situation/concern/symptom? \_\_\_\_\_

20. Since the development of this situation/concern/symptom:

(a) Have you changed any habits? \_\_\_\_\_

(b) Held or touched part of your body more often or differently? \_\_\_\_\_

(c) Moaned, cried, or made sounds that you usually do not make? \_\_\_\_\_

21. Which best describes your current feeling about yourself and your situation/concern/symptom:

\_\_\_ I feel helpless, like little or nothing works.

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

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

\_\_\_ I deserve more than what I have been experiencing, and I would like you to assist me in my healing.

Anything else? \_\_\_\_\_

22. Please grade the following in order of increasing intensity:

**0 - not at all                      1 – slight                      2 – moderate                      3 - extreme**

Currently, how inconvenient is your condition/symptom/concern?

0 1 2 3

How inconvenient was it in the past?

0 1 2 3

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

1. Have you ever injured your spine (neck, head, back, hips)? Yes\_\_ No\_\_

(a) Date of most significant injury: \_\_\_\_\_

(b) What happened? \_\_\_\_\_

(c) Date of most recent injury: \_\_\_\_\_

(d) What happened? \_\_\_\_\_

2. Please list medications (prescription or non-prescription) you have taken within the past 60 days: \_\_\_\_\_

3. In past, have you taken other medications for period more than three consecutive months? Yes\_\_ No\_\_

(a) What did you take? \_\_\_\_\_

(b) What was the reason for taking this medication? \_\_\_\_\_

4. Have you had spinal X-rays, CT scans, or MRI imaging of your: neck, head, back, hips? Yes\_\_ No\_\_

If yes, when? \_\_\_\_\_

5. What were you told about them? \_\_\_\_\_

6. Where are these films now? \_\_\_\_\_

7. Have you had any surgeries? Yes\_\_ No\_\_

If yes, please explain: \_\_\_\_\_

8. Have you broken any bones or significantly sprained a part of your body? Yes\_\_ No\_\_

If yes, please explain: \_\_\_\_\_

9. Please list any herbs, nutritional supplements or natural remedies you take regularly: \_\_\_\_\_

10. Have you consulted a physician or any other health care provider in the past 3 months? Yes\_\_ No\_\_

If yes, please explain: \_\_\_\_\_

11. Has your spine ever been professionally adjusted/manipulated/entrained? Yes\_\_ No\_\_

(a) By whom and when? \_\_\_\_\_

(b) Why did you go? \_\_\_\_\_

(c) Are you still going? Yes\_\_ No\_\_

(d) What did he/she do for you? \_\_\_\_\_

(e) Were you pleased? Yes\_\_ No\_\_

(f) Have you received Network Spinal Analysis Care? Yes\_\_ No\_\_

(g) Has your family received Network Spinal Analysis Care? Yes\_\_ No\_\_

12. Do you consult with a physician for any other than routine evaluations? Yes\_\_ No\_\_

13. What is/was the reason for the visit(s)? \_\_\_\_\_

14. When was your last visit? \_\_\_\_\_

15. What was done or suggested? \_\_\_\_\_

16. Have you experienced the following health treatments or healing modalities? If so, please describe when you went, for how long you went, and what the results were:

\_\_\_ Chiropractic \_\_\_\_\_

\_\_\_ Bodywork/Massage \_\_\_\_\_

\_\_\_ Emotional Therapy/Psychotherapy \_\_\_\_\_

\_\_\_ Osteopathy/Cranial work \_\_\_\_\_

\_\_\_ Physiotherapy/Occupational Therapy \_\_\_\_\_

\_\_\_ Music/Dance/Sound/Light/Aromatherapy \_\_\_\_\_

\_\_\_ Homeopathy/Herbalist \_\_\_\_\_

\_\_\_ Ayurvedic Medicine \_\_\_\_\_

\_\_\_ Oriental Medicine/Acupuncture \_\_\_\_\_

\_\_\_ Nutritional Counseling/Therapy \_\_\_\_\_

\_\_\_ Oxygen Therapy/Chelation Therapy \_\_\_\_\_

\_\_\_ Rebirthing/Breathwork \_\_\_\_\_

\_\_\_ Meditation/Yoga/Prayer/Movement/Dance/Tai Chi/Chi Gong or Exercise \_\_\_\_\_

\_\_\_ Somato Respiratory Integration Care \_\_\_\_\_

\_\_\_ Other \_\_\_\_\_



8. What would motivate you to communicate to others about the care you receive in this office and to encourage others to seek care? \_\_\_\_\_

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***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. We are excited about the possibility of assisting you as you continue on your journey towards greater health and wellness.***

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Signature

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Date (MM/DD/YY)