

CENTER FOR HOLISTIC HEALTH : COMPREHENSIVE HEALTH PROFILE

Last Name: _____ First Name: _____ Today's Date: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone _____ E-Mail _____ Date of Birth _____

How did you discover our office, and the professional services we offer?

Please complete this general health history survey, as it will provide your doctor with important information to better understand your history, your present and longer term needs, and any compromise to your wellness or health related quality of life that you may now be experiencing.

Part I: Your Health Concerns or Symptoms and How They May Affect Your Life

1. Do you have any current health concerns? If so please describe

2. When did this situation or concern begin? _____

3 Have you done anything about this situation or concern or gotten any 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 condition or symptom after treatment? _____

8 What was different about your concern about the condition or symptom after 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.

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 0 1 2 3

Comments _____

10 Have any other family members had the same or similar concerns? Yes No

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 time, or activity you can be involved with when you totally or almost totally forget about this condition, symptom or concern about this? _____

14 Is there any time of day or activity which makes you more aware of it? _____

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 condition or symptom were to go away tomorrow, what would be different about your life?

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

12. Do you consult with a physician for 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 had experience with the following health, treatment or healing modalities? If so, please describe when you went, for how long you went, and what the results were:

Massage/ Bodywork _____

Emotional Therapy/Psychotherapy: _____

Osteopathy: _____

Pysiotherapy/Occupational Therapy: _____

Music/Dance/Sound/Light/Aromatherapy: _____

Homeopathy/Herbalist: _____

Ayurvedic Medicine: _____

Oriental Medicine/Accupuncture: _____

Nutritional Counseling/Therapy: _____

Oxygen Therapy/Chelation Therapy: _____

Rebirthing/Breathwork: _____

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

Somato Respiratory Integration _____

Other _____

17. Do you have an exercise, meditation, prayer, nutritional or dietary program? Explain:

18. When stressed, how do you “center yourself” or “re-group”?

Part III Stress Survey: Please grade the following stresses in order of increasing intensity.

0- means no awareness of any stress

1- slightly stressful situation

2- moderately stressful situation

3- extremely stressful situation

1) **Overall Physical Stress, Trauma:** Includes: falls, accidents, injuries, repeated postural stress impacts, difficult birth, traction, physical abuse:
0 1 2 3

2) **Overall Emotional/Mental Stress:** Includes: loss of love ones, rapid change in life situation, mental, emotional sexual abuse, legal concerns, financial concerns, move of home/school, separation/divorce etc in relationship, stress of being ill etc
0 1 2 3

3) **Overall Chemical Stress:** Includes drugs, smoke, fumes, food additives etc
0 1 2 3
Comments:

4) Have you had a work/ vehicular accident related injury? yes no
Please describe _____

Part IV: Your Specific Needs and Hopes For Help in This Office?

Use this scale for questions 1 and 2:

- a) *very important to me* b) *important to me*
c) *not so important to me* d) *does not apply*

1. Which of the following five choices is currently of most interest to you. 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. How do you hope to benefit from care in the office?

- 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 constructive choices
- e) Overall improved quality of life

2. For a slightly longer term goal, how do you hope to benefit from care in the office?

- 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 constructive choices
- e) Overall improved quality of life

3 Is there some aspect of your life that very much pleases you, brings you joy, or helps you to feel better about yourself? _____

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

5. Are there any particular factors or elements about your life, experiences, family, work, recreation, past injuries, genetics, dietary programs, exercises, outlook, etc that you feel give you an edge, or adds to your health? _____

Your answers to the following questions will help us to help you to better participate in a program of care specifically focused on your spine your nervous system and your health and wellness.

6 When communicating to you about your spine, nervous system, health and wellness (circle your preference)

- a) Mostly speak with me about the clinical findings and tell me about the changes I am making
- b) Mostly show me in written form the clinical findings, and 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

7 Is there anything else which may help us to understand you, your history, or your professional needs which have not been discussed on this survey? Please explain: _____

8 What would motivate you to tell others about the care you receive in this office, and encourage others to get in care? _____

Thank you for choosing our Chiropractic Office. We are looking forward to helping you to be successful in your ability to develop a healthy spine and nervous system We are excited about the possibility of assisting you as you continue on your journey towards greater health and wellness.

