



## COMPREHENSIVE HEALTH PROFILE

Last Name \_\_\_\_\_ First Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Zip \_\_\_\_\_ E-Mail \_\_\_\_\_ Date of Birth \_\_\_\_\_

Home Phone \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

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

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**\*\*Please complete this general health history survey, as it will provide us 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 Affect Your Life

*For any of these questions, please use the back of the page if you need more space.*

1. What are your current health goals? Please describe.

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2. When did this situation or concern begin? \_\_\_\_\_

3. Have you done anything about this situation or gotten advice or treatment for it? Y N

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?

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9. Please grade the level to which this health concern(s) affects these aspects of your functioning or 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 or symptom?

\_\_\_\_\_

20. Since this happened,

Have you changed any habits? \_\_\_\_\_

Held or touched part of your body more or differently? \_\_\_\_\_

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

21. Which best describes your current feeling about yourself and your situation? Check one.

\_\_\_\_\_ 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 have been experiencing.

\_\_\_\_\_ I would like you to assist me in my healing.

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

22. Please grade the following. 0-not at all, 1-slight, 2-moderate, 3-extreme

Currently, how inconvenient is your situation, condition or symptom? 0 1 2 3

How inconvenient was it in the past? 0 1 2 3

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

*For any of these questions, please use the back of the page if you need more space.*

1. Have you ever injured your spine, neck, head, back or hips?
  - a) Date of most significant injury: \_\_\_\_\_
  - b) What happened? \_\_\_\_\_
  - c) Date of most recent injury: \_\_\_\_\_
  - d) What happened? \_\_\_\_\_
2. Have you had a work or vehicular accident-related injury? Yes No Please describe:  
\_\_\_\_\_
3. Please list medications (prescription or non-prescription) you have taken within the past 60 days:  
\_\_\_\_\_
4. In the past, have you taken other medications for a period of more than 3 months? Yes No
  - a) What did you take? \_\_\_\_\_
  - b) What was the reason for taking this medication? \_\_\_\_\_
5. Have you had any spinal X-rays, Cat scans or MRI imaging of your spine, head, neck, back or hips? Yes No When? \_\_\_\_\_
6. What were you told about them? \_\_\_\_\_
7. Where are these films now? \_\_\_\_\_
8. Have you had any surgeries? Please explain? \_\_\_\_\_
9. Have you broken any bones or significantly sprained part of your body? Yes No  
Please explain: \_\_\_\_\_
10. Please list any herbs, nutritional supplements or natural remedies you take regularly. \_\_\_\_\_  
\_\_\_\_\_
11. Have you consulted a physician or any other health-care provider in the past three months?  
\_\_\_\_\_
12. Has your spine ever been professionally adjusted? 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) Does anyone in your family receive chiropractic care? Yes No
13. Do you consult with a physician for other than routine evaluations? Yes No
14. What is (was) the reason for the visit? \_\_\_\_\_
15. When was your last visit? \_\_\_\_\_

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

17. Have you had experience with the following health, treatment or healing modalities? If so, please describe when, for how long and what the results were:

Massage or Bodywork \_\_\_\_\_

Emotional Therapy or Psychotherapy \_\_\_\_\_

Osteopathy \_\_\_\_\_

Physiotherapy or 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 \_\_\_\_\_

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

\_\_\_\_\_

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

\_\_\_\_\_

**Part III Stress Survey: Please grade the following stresses using the following scale.**

0 - 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 Comments: \_\_\_\_\_

2) Overall Emotional/Mental Stress. Includes: loss of loved 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.

0 1 2 3 Comments: \_\_\_\_\_

3) Overall Chemical Stress: Includes drugs, smoke, fumes, food additives, etc.

0 1 2 3 Comments: \_\_\_\_\_

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

Use this scale for Questions 1 and 2

0 - does not apply    1 - very important to me    2 - important to me    3 - not so important

1. Which of the following 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. Please score the following improvements based on your level of desire for benefit from care.

- \_\_\_\_\_ Improvement of my physical symptoms
- \_\_\_\_\_ Improvement of emotional/mental symptoms
- \_\_\_\_\_ Improvement of 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. For a slightly longer-term goal, how do you hope to benefit from care in the office?

- \_\_\_\_\_ Improvement of my physical symptoms
- \_\_\_\_\_ Improvement of emotional/mental symptoms
- \_\_\_\_\_ Improvement of 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 very much pleases you, brings you joy, or helps you to feel better about yourself? \_\_\_\_\_

4. Are there any particular factors or elements of 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? \_\_\_\_\_

6. When communicating to you about your spine, nervous system and wellness (circle one)
- 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 I'm making.
  - c) Mostly let me get a sense of the clinical work and 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 has not been discussed on this survey? Please explain on back of this page.

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 The Center for Holistic Health.** We are excited about the possibility of assisting you on your journey towards greater health and wellness!