Dr. Maureen Neskar
Momentum to Wellness Studio
238 Mutual Street, Toronto
647 435 5930

COMPREHENSIVE HEALTH PROFILE

Last Name: _____ **First Name**: _____ **Date**: (dd/mm/yyyy)**:** _____

Address: _____ **City**: _____ **Prov.:** _____ **Postal code**: _____

Home phone: _____ **Work phone:** _____ **ext.** _____ **Cell phone**: _____

E-mail address:_____ **Occupation**: _____

Date of birth (dd/mm/yyyy)**:** _____ **Sex**: F☐ M☐ **Status**:_____ **Children**: _____

How did you discover our office? _____

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

Part I: 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 received 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. Is there anything that makes this concern worse? _____

   _____

10. Is there anything that makes this concern better? _____

    _____

11. Please grade the level to which these health concerns affect these aspects of your functioning/quality of life. Use this scale for all questions on this page.

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

___ Effects on work	____ Effects on recreation/play	___ Effects on rest/sleep
___ Effects on social life	____ Effects on walking	___ Effects on sitting
___ Effects on exercise	____ Effects on eating	___ Effects on love life
___ Concern about particular symptom/condition		___ Concern about health

Comments: _____

12. Has any other family member had the same or similar concerns? Yes ☐ No ☐
13. What did he/she do about them? _____
14. Did it seem to work? _____
15. Using the scale above, (0 – 3), how aware of this are you during the day?_____ at night? _____
16. Is there any time of day, or activity you do when you totally, or almost, forget about this condition, symptom or concern? _____
17. Is there any time of day or activity which makes you aware of it? _____
18. Why do you think this has happened or continues to happen to you?

_____

19. Do you think this is the sole cause? Yes ☐ No ☐
20. If no, what else is involved? _____

_____

21. If this condition or symptom were to go away tomorrow, what would be different in your life?

_____

_____

22. What are you doing in your life now that is different that what you would be doing if you did not have this condition/symptom in your life _____

_____

23. Since this happened, have you changed any habits? _____

_____

24. Which best describes your current feeling about yourself and your situation?

_____

Anything else? _____

25. Please grade the following on a scale of **0 - not at all 1 - slight 2 - moderate 3 – extreme**

a) Currently, how inconvenient is your situation, condition or symptom? _____

b) How inconvenient was it in the past? _____

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

1. Have you ever injured your spine (☐Neck,☐Head,☐Back,☐Hips)?
   a) Date of most significant injury (dd/mm/yyyy): _____
   b) Explain what happened? _____
   c) Date of the latest injury (dd/mm/yyyy): _____
   d) Explain what happened? _____
   e) Have you ever been knocked unconscious? Yes☐ No☐
   f) Have you ever used crutches, a cane or a walker? _____
2. Please, list medications (prescription or non prescription) you have taken within the past 60 days:

   _____
3. 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? _____
4. Have you had any spinal X-rays, Cat scans or MRI imaging of your spine or head (neck, back or hips)?
   Yes☐ No☐ When (dd/mm/yyyy)? _____
5. What were you told about them? _____
6. Have you had any surgeries? Yes☐ No☐
   Please explain: _____
7. Have you broken any bones, or significantly sprained part of your body? Yes☐ No☐
   Please explain _____
8. Please list any herbs, nutritional supplements or natural home remedies you take regularly.

   _____
9. Have you consulted a physician or any other health care provider in the past three months?
   Yes☐ No☐ Please explain _____
10. 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 your family receive chiropractic care? Yes☐ No ☐
11. Do you consult with a physician for other than routine evaluations? Yes☐ No ☐
12. What is/was the reason for the visit(s)? _____
13. When was your last visit (dd/mm/yyyy)? _____
14. What was done or suggested? _____

15. 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 _____

Physiotherapy/Occupational Therapy _____

Music/Dance/Sound/Light/Aromatherapy _____

Homeopathy/Herbalist _____

Ayurvedic Medicine _____

Oriental Medicine/Acupuncture _____

Nutritional Counseling/Therapy _____

Oxygen Therapy/Chelation Therapy _____

Rebirthing/Breathwork _____

Yoga/Dance/Tai Chi/Chi Gong/ Meditation/Prayer _____

Somato Respiratory Integration _____

Other: _____

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

_____

Part III: Stress Survey

1. With each of the following stress situations, please ✓ either Past, Present or all that apply

	Mild		**Moderate**		**Extreme**	
	Past	Present	Past	Present	Past	Present
Childhood stress	☐	☐	☐	☐	☐	☐
School stress	☐	☐	☐	☐	☐	☐
Play, or recreational	☐	☐	☐	☐	☐	☐
Family Stress	☐	☐	☐	☐	☐	☐
Personal relationships	☐	☐	☐	☐	☐	☐
Stress of being sick	☐	☐	☐	☐	☐	☐
Work related stress	☐	☐	☐	☐	☐	☐
Stress of commuting	☐	☐	☐	☐	☐	☐
Loss of loved one	☐	☐	☐	☐	☐	☐
Change in lifestyle	☐	☐	☐	☐	☐	☐
Change in vocation	☐	☐	☐	☐	☐	☐
Abuse	☐	☐	☐	☐	☐	☐

2. Have you ever had a work/vehicular accident or injury? Yes ☐ No ☐
   Please describe: _____
3. Do you have a regular exercise or a sport you enjoy? Yes ☐ No ☐
   Please describe: _____

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

1. In a published study of over 2,800 international 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. **Which of the following five choices is currently of most interest to you & how do you hope to benefit from care in this office?**

   Please indicate below: **A) very important to me** **B) important to me**
   C) not so important to me **D) does not apply**

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

   _____

   _____

3. 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?

   _____

   _____

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 give you an edge or adds to your health?

   _____

   _____

5. Do you smoke now? Yes ☐ No ☐ If yes, when did you start (dd/mm/yyyy)? _____
6. Have you ever smoked? Yes ☐ No ☐ If yes, when did you quit (dd/mm/yyyy)? _____
7. Do you consume alcohol? _____

8. On a scale of 1, being worst to 10, being best, how would you rate your diet? _____
   Explain: _____

9. Do you consume any of the following on a regular basis? Please check for yes:

   ☐ Coffee ☐ Diet Food ☐ Artificial Sweeteners
   ☐ Fried Food ☐ Organic Food ☐ Fish
   ☐ Poultry ☐ Red Meat ☐ Pork ☐ Dairy

10. Do you, or did you, work with any chemical, fume, dust, powder, smoke etc. for long periods(s) of time? Yes☐ No☐
    Please explain when and how: _____
    _____

11. What would motivate you to tell others about the care you receive in this office and encourage others to receive care?
    _____
    _____

12. FOR WOMEN ONLY
    Date of last menstruation (dd/mm/yyyy): _____ Birth control: Yes☐ No☐
    Type: _____

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

Any further comments for Dr. Neskar:

_____
_____
_____
_____
_____

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