

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): _____ Gender: 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. *There is extra space on the last page if you need it.*

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 than 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

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. Nesar:

Dr. Maureen Nesar
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