Comprehensive Health Profile

Name: ______________________________ Date: ______________________________

Address: __________________________ City: _______________ Postal Code: _______________

Home Phone #:_______________ Work Phone #: _______________ Cell Phone #: _______________

Email: ______________________________ Best time to contact: __________ At Which # __________

Date of Birth:_____/_____/_____ Age: ________Height: _______ Weight:_______ Marital Status: S M W D CL
Day / Month /

Number of Children: F - _______ M - _______ Who referred you to our Centre?______________________________

Occupation:______________________ Where do you work? ______________________________

Have you had any chiropractic care in the past? YES or NO Were you pleased with the care? YES or NO

PLEASE ANSWER THE FOLLOWING QUESTIONS ABOUT YOUR PERSONAL HISTORY

1.Please check the box next to the statement(s) that apply to you:
I am interested in:
- Optimizing or enhancing my current level of wellness
- Addressing a specific health concern(s)

Please list and describe any health concern(s):____

____

____

2.Please grade and circle the level to which this health concern(s) affects the following 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 of 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 of 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 Health and Well-Being	0 1 2 3			Concern about Particular Symptom/Condition	0 1 2 3

3.Have you done anything or sought treatment for your major situation or concern? YES or NO If NO, go to #7
If YES, what were you told?______________ ____

4.What was done?____ Did it seem to work?______________

5.What was different about YOU, after treatment?_____ ____

6.What was different about your CONDITION or SYMPTOM after treatment? ______________________________

7.Why do you think this has happened (or continues) to happen to you?______________________________
Do you think this is the sole cause? YES or NO If NO, what else is involved?______________________

8.How do you feel about your current condition? (Please choose ONE that BEST describes how you feel)

- I feel helpless; nothing works.
- I don't like what I am feeling, and I hope you can fix it.
- I feel this is a pattern that has happened to me before; it is back again.
- I feel there is a message my body is giving me.
- I am looking for something to help me enhance my quality of life and further enhance my wellness.

OVERALL STRESS SURVEY

Please circle your Past/Current Life Stresses using the following scale:

0 - *No* awareness of any stress   1 - *Slight* stress   2 - *Moderate* stress   3 - *Extreme* Stress

A) Overall PHYSICAL STRESS/TRAUMA: (includes: falls, accidents, injuries, repeated postural stress, impacts, difficult birth, physical abuse, loss of consciousness, broken/fractured bones, etc.) 0 1 2 3

B) Overall EMOTIONAL/MENTAL STRESS: (includes: loss of loved ones, rapid change in life situations, abuse, move of home/school, legal concerns, financial concerns, divorce, relationships, etc.) 0 1 2 3

C) Overall CHEMICAL STRESS: (includes: prescription drugs from surgery, over-the-counter medications, smoke, alcohol, caffeine, fumes, food additives, anesthesia from surgery, etc.) 0 1 2 3

PHYSICAL HISTORY

BIRTH STRESS: Information about your birth history:

1) Did your mother have a difficult pregnancy with you? YES or NO
2) Was your birth traumatic? YES or NO
3) Was your birth: Drug induced Forceps or suction Prolonged C-section Cord around the neck Breech Natural Other:____________ __________________________

GENERAL PHYSICAL TRAUMA:

4) Have you ever been knocked unconscious? YES or NO
   How/When?____
5) Have you ever broken any bones? YES or NO Which Ones?___________________________ _______________
6) Have you ever had any impacts, falls, that you feel specifically may have injured your spine? YES or NO
   How/When?____
7) Have you ever injured your head, neck, back or hips? YES or NO
   How/When?____ _______________________

SPORTS OR LEISURE:

8) Were you, or are you active in any sport(s)? YES or NO Which ones?___________________________
9) Have you ever been hurt in any of these activities? YES or NO Where?___________________________

AUTOMOBILE ACCIDENTS:

10) Have you, (even as a passenger, even if you do not think you were hurt), been involved in a car accident, or near collision? Please list approximate dates and severity:____
    Bus, bicycle, motorcycle, train, airplane, moped or other vehicles:________________________ _________________________

MEDICAL TREATMENT:

11) Have you ever been hospitalized? YES or NO If YES, what was done to you?_______________________________
12) Have you had surgery? YES or NO If YES, what was done to you?_______________________________
13) Have you ever had: Spinal tap Spinal Injections Physiotherapy Neck collar Spinal brace Heel lift X-Ray Treatments Traction Corrective Shoes or Bars Extensive Diagnostic X-Rays Acupuncture Chemotherapy Transfusion Body Part in a Cast or Immobilized?

CHEMICAL HISTORY

GENERAL CHEMICAL TRAUMA:

1) Are you now taking any drug(s) (prescription or over-the-counter)regularly? Please list drug(s), when prescribed and reasons for taking them:____
   ____
2) Do you now, or in the past have a history of alcohol/drug abuse or heavy use? YES or NO
   If YES, please describe:____
3) Do you or did you work with any chemical, fume, dust, powder, smoke for prolonged periods? YES or NO
4) Please indicate how much of the following products you consume:
   Alcohol-Drinks/week ____________Coffee - Cups/day ____________Tobacco-Amount/day ___________
   Artificial Sweeteners YES or NO Refined sugar-candy, pastries, etc/day _________ Soft drinks-#/Day _________
5) Do you regularly take nutritional supplements? NO or YES Please list:___________ __________________________

EMOTIONAL HISTORY

GENERAL STRESS EFFECTS:

1.With each of the following potential spinal stress situations, please indicate the severity either past or current.

Potential Spinal Stress/Tension Sources	Past			Current		
Childhood Stress	Mild	Moderate	Extreme	Mild	Moderate	Extreme
School Stress	Mild	Moderate	Extreme	Mild	Moderate	Extreme
Family Stress	Mild	Moderate	Extreme	Mild	Moderate	Extreme
Personal Relationships	Mild	Moderate	Extreme	Mild	Moderate	Extreme
Stress of Being Sick	Mild	Moderate	Extreme	Mild	Moderate	Extreme
Work Stress	Mild	Moderate	Extreme	Mild	Moderate	Extreme
Stress of Commuting	Mild	Moderate	Extreme	Mild	Moderate	Extreme
Loss of a Loved One	Mild	Moderate	Extreme	Mild	Moderate	Extreme
Change in Lifestyle	Mild	Moderate	Extreme	Mild	Moderate	Extreme
Change in Vocation	Mild	Moderate	Extreme	Mild	Moderate	Extreme
Abuse (Verbal, Physical, Emotional, Sexual, etc)	Mild	Moderate	Extreme	Mild	Moderate	Extreme

YOUR SPECIFIC NEEDS AND HOPES FOR HELP AT THIS CENTRE

1. In a published study of health and wellness benefits for patients under Network Care, conducted at the University of California, Irvine Medical College, patients reported an overall improvement in all of the following categories of health and wellness listed below (highlighted in **BOLD**). How do you hope to benefit from care in this office? (Use the following to answer each category).

   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** _____ Overall improvement in **Quality of Life**

   _____ Improvement in **Enjoyment of Life** and the ability to make **Healthier, more Constructive Choices**

2. Is there anything else you may wish to share which may help us to better understand you, your history, or your professional and personal needs which have not been discussed in this profile? (If necessary, please use the back of this form)

   ____
   ____
   ____

***See over for informed consent**

Network Spinal Analysis (NSA) Consent Form

I hereby request and consent to receiving an examination of my spine and its associated tissues, supportive wellness education and subsequent spinal care. This will be performed at this Centre by a chiropractor(s) who provides **Network Spinal Analysis** (NSA) Care, a low force approach which has unique outcomes and clinical results. This practitioner(s) chooses to practice NSA, as he/she is professionally and personally confident in regard to the safety and effectiveness of this form of care.

The purpose of this consent form is to help me better understand the nature of the services offered at this Centre and our mutual responsibilities. This fosters a more effective relationship and avoids misunderstandings regarding expectations. Having well understood expectations is anticipated to promote a greater sense of safety and healing.

NSA does not attempt to manually, or by instrument, manipulate spinal fixations structurally (often associated with a snapping or popping sound), nor does it directly treat painful areas of the spine and body. ***Instead, by enhancing my body's awareness of itself and specifically my spine, I understand I can develop new strategies for healing, adapting to stress, and experiencing wellness. These strategies promote spontaneous self-correction and self-regulation of spinal tension patterns and healing.***
NSA consists of gentle touch contacts along the neck and back known as entrainments to achieve greater communication between the brain and body, and new sensory and motor strategies. NSA adopts an approach associated with somatic (body/spinal awareness) training.

At regular intervals, following commencement of care, reassessments will be performed. These will include my personal perception of my wellness and my awareness of my spine and body-mind changes. My chiropractor(s) will report to me the improvement in my spinal and nervous system integrity and my ability to self-regulate tension and to reorganize my spine.

I also understand that, in addition to NSA care and wellness education, my practitioner(s) may perform additional examinations or assessments and offer health/spinal care or advice that is consistent with my individual needs. I also acknowledge I may be seen by another associate NSA Chiropractor of this Centre from time to time due to seminars, holidays, etc.

It has been explained to my satisfaction, and I understand that the care offered at this Centre is not a form of, or replacement for, the diagnosis or treatment of any symptom, disease, or malady. Instead, it is a form of wellness care and self-education that empowers my connection with my body-mind and develops new strategies for spinal and nervous system integrity and wellness. It develops new capacities in my body for the identification of, spontaneous release of, and redirection of tension.

It is common for people receiving NSA care to breathe more deeply and more fully, engaging the spine with their respiration, to spontaneously adapt postures that release or redistribute tension, to bust stress, and to experience more of their inner life energy. I understand it is common to experience a wider range of motion and emotion during care. It is common, as care progresses, to find new options in the body and in life, which often lead to significant life changes.

This form of care is NOT suggested for those individuals who wish to remove a symptom or condition without the occurrence of other fundamental changes in their lives. The care at this Centre often promotes significant changes in health choices, lifestyle, experience of the body-mind, emotion, and consciousness.

Rather than attempting to simply return me to my previous state minus a symptom, this chiropractor instead chooses to help me achieve new levels of wellness and life potential that I may never have had before.

As a chiropractor the sole condition of our clinical concern is that of the vertebral subluxation. In Network Care, we categorize these subluxations into two categories, a structural segmental distortion and a spinal cord/ nerve elongation or stretching. Through the gentle touch applications at the spine to enhance spinal and nerve system integrity, subluxations are corrected. This is the only condition that we address at our Centre.

The only condition we offer to diagnose and correct is the vertebral subluxation and loss of spinal and neural integrity in relationship to this. We do not offer to diagnose or treat any other condition, disease, or symptom. If during the course of our spinal assessment/examination we encounter non-chiropractic or unusual findings, we will advise you of this. If you desire advice on further diagnosis or treatment of this condition, situation or circumstance, we will recommend that you seek the services of another health care provider whose practice is geared towards such differential diagnosis and treatment.

I have read, or have had read to me, the CONSENT TO RECEIVE A NETWORK SPINAL ANALYSIS (NSA) EXAMINATION AND APPROPRIATE SUBSEQUENT CARE. I understand that the care at this Centre is different from what many consumers may expect from chiropractors practicing manipulative therapy. I agree to receive care, which consists of or includes NSA care and wellness education. I understand that I am not passive in this process, but that I am an active participant in my care and in my healing.

____________________	____________________	____________________
DATE	PRINTED NAME OF PRACTICE MEMBER (Client)	SIGNATURE OF PRACTICE MEMBER (Client) OR LEGAL GUARDIAN

____________________	____________________	____________________
DATE	PRINTED NAME OF CHIROPRACTOR	SIGNATURE OF CHIROPRACTOR