

Comprehensive Health Profile / History

Please check the type of care desired:

Temporary Relief Stabilization Family Health/ Prevention Doctor's Advice

Name: _____ Sex: Male / Female

First Middle Last

Address: _____

Street City State Zip Code

Home Phone: _____ Cell Phone: _____

(Please star the best number to reach you at.)

Date of Birth: ___/___/___ Age: ___ Weight: ___ Height: ___ SS#: _____

Marital Status: S M D W Significant Other's Name: _____

No. of Children: ___ Children('s) Name(s) and Age(s): _____

Spouse/other emergency contact: Name _____ Phone _____

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

If you were referred, who referred you? _____

Your Health Concerns or Symptoms and How They May Affect Your Life

If female, do you suspect or know that you are pregnant? Yes No

Do you have any current health concerns? _____

When did this situation or concern begin? _____

Is this related to an auto accident injury on the job other injury (_____)

Date of most recent flare-up: _____

Have you had this or something similar before? N Y When? _____

What did you do about it then? _____

Have you done anything for this or gotten any advice or treatment for it? Yes No

If yes, what were you told? _____

What was done? _____

Did it seem to work? _____

What was different about you, after treatment? _____

What was different about your condition or symptom after treatment? _____

What was different about your concern about the condition or symptom after treatment? _____

Does it interrupt your sleep? No Yes How? _____

Does it affect your work home life decision making attitude mood

productivity patience ability to do perform household duties

ability to exercise/ play sports ability to relax/ do hobbies ability to be intimate

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

What did they do about them? _____

How aware are you of this during the day? _____

At night? _____

Is there any time of day or activity that makes you more aware of it? _____
Why do you think this has happened or continues to happen to you? _____

Do you think this is the sole cause? _____
If no, what else is involved? _____
If this condition or symptom were to go away, what would be different about your life? _____

What are you doing differently in your life because of this condition/symptom? _____

Since this happened, have you:
____ changed any habits ____ held or touched part of your body more or differently?
Which best describes your current feeling about yourself and your situation?
a) I deserve more than what I have been experiencing, and would like for you to assist me in my healing.
b) This is terrible/really bad and I hope you can fix it for me.
c) I feel helpless, like little or nothing works.
d) Other: _____

Currently, how inconvenient is your situation, condition, or symptom? _____
In the past? _____

Health/Trauma/Medical/Chiropractic and Healing History

Have you ever injured your spine (neck, head, back, hips)? _____

Please list all accidents and falls, even if you “didn’t get hurt” in them (including all auto collisions, sports and childhood related injuries): _____

Medications you are *currently* taking, including prescription, non-prescription, and birth control (please include your reason for taking them): _____

Vitamins or supplements you are *currently* taking (please include your reason for taking them): _____

Medications you have taken in the *past* for a period of longer than 3 months, including prescription, non-prescription, and birth control (please include your reason for taking them): _____

Vitamins or supplements you have taken in the *past* for a period of longer than 3 months (please include your reason for taking them): _____

What were you told (if anything) about the medications, vitamins, or supplements you currently take or have taken? _____

Did you do any research for yourself on any medications, vitamins, or supplements you use/have used? _____

Have you had any surgeries? _____

Have you broken any bones, or significantly sprained part of your body? _____

Have you consulted a physician or other health care professional in the past three months? _____

Has your spine ever been *professionally* adjusted? Yes No
 Have you ever been to a chiropractor before? Yes No
 Who? _____ When? _____
 Duration of care: _____ Reason for visit: _____
 Are you still going? Yes No Result: _____
 Were you pleased? Yes No Technique used: _____
 Does your family currently receive chiropractic care? Yes No
 If no, have they in the past? Yes No
 Were you and/or your family ever under preventative chiropractic care? Yes No

Check each you have had in the past or have now. Put "P" for past and "N" for now.

- | | | |
|--|---|--|
| <input type="checkbox"/> Weight changes | <input type="checkbox"/> Frequent infections | <input type="checkbox"/> Respiratory disease |
| <input type="checkbox"/> Sinus problems | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Hardening of arteries |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Asthma | <input type="checkbox"/> Numbness/Tingling |
| <input type="checkbox"/> Cold hands | <input type="checkbox"/> Cold feet | <input type="checkbox"/> High cholesterol |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Nervous disorder | <input type="checkbox"/> Digestive problems |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Menstrual problems/ pain | <input type="checkbox"/> HIV or AIDS |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Headaches (___x/___) |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Stress difficulty | <input type="checkbox"/> Surgery |
| <input type="checkbox"/> Diabetes (Type:_____) | <input type="checkbox"/> Arthritis (OA or RA?) | <input type="checkbox"/> Jaw trouble |
| <input type="checkbox"/> Changes in bowel/bladder habits | <input type="checkbox"/> Concussion /Head injury | <input type="checkbox"/> Neurological issues |

Other: _____
 Family history of any of those listed? No Yes Which and who? _____

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

Massage/Body Work _____
 Emotional Therapy/Psychotherapy/Counseling _____
 Osteopathy _____
 Physical Therapy/Occupational Therapy _____
 Homeopathy/Herbalist _____
 Music/Dance/Sound/Light/Aromatherapy _____
 Ayurvedic Medicine _____
 Oriental Medicine/Acupuncture _____
 Nutritional Counseling _____
 Breath work/Yoga/Tai Chi/Chi Gong _____
 Other: _____

When stressed, how do you "center yourself" or "regroup"? _____

Do you participate in any sports or teams, whether as a hobby or otherwise? No Yes
 What? _____

Exercise habits: (what activities, how long, how often) _____
 Age of sneakers worn: _____

Often our own birth is the most traumatic experience our bodies ever endure. Our brains, spinal cords, and spines are wrenched, twisted and pulled as we exit the birth canal in even the easiest, most natural birth. Any interference from outside (doctors, instruments, procedures, medications) can further traumatize a newborn's fragile system.

What do you know about your birth? (Were you born at the hospital or at home? Was their ANY intervention? i.e. forceps, vacuum extraction, medication, caesarean section, etc.) _____

Other Important Lifestyle Information

Occupation: _____

Employer: _____ Work Phone: _____

Do you enjoy what you do? ___N ___Y Explain: _____

Duties/ Habits: ___ sit more than 1 hour ___ carry equipment/tools on your body (i.e. utility belt)

___ repetitively bend or twist ___ cradle the phone shoulder to ear (which side? L or R)

___ repetitively type ___ drive on the job (car or other) ___ lift more than 10 lbs repetitively

Are you currently on a work release? ___N ___Y Ordered by whom? _____

Sleep position: ___Back ___Stomach ___Side (L or R?) Pillows: # ___ where? _____

Age of mattress: _____ Age of pillows: _____ Sleep disturbances? _____

Hours of sound sleep per night? _____

Habits:	Heavy	Moderate	Light	None
Alcohol	_____	_____	_____	_____
Coffee	_____	_____	_____	_____
Drugs (OTC & recreational)	_____	_____	_____	_____
Non-herbal tea	_____	_____	_____	_____
Tobacco	_____	_____	_____	_____
Soda	_____	_____	_____	_____
Energy drinks	_____	_____	_____	_____
Fast food	_____	_____	_____	_____
Candy	_____	_____	_____	_____
Dairy	_____	_____	_____	_____
Meat	_____	_____	_____	_____
Vegetables	_____	_____	_____	_____
Fruit	_____	_____	_____	_____
Daily water intake	_____	_____	_____	_____

Anything else you think we should know? _____

Stress Survey:

0 – no awareness of any stress

2- moderately stressful situation

1- slightly stressful situation

3- extremely stressful situation

Overall Physical Stress, Trauma:

0 1 2 3

Includes: falls, accident, injuries, repeated postural stress, impacts, difficult birth, physical/sexual abuse, etc.

Overall Emotional/ Mental Stress:

0 1 2 3

Includes: loss of loved ones, rapid changes in life, mental/emotional/sexual abuse, legal concerns, financial concerns, separation/divorce/break up, move of home/school, stress of being ill, job stress, etc.

Overall Chemical Stress:

0 1 2 3

Includes: drugs, medicines, alcohol, nicotine, caffeine, smoke, fumes, chemical agents, pollution, food additives, poor diet (fast food, fried food), etc.

Your Specific Needs and Hopes for Help at Lotus of Life Chiropractic

Which of the following five choices is currently of most interest to you? How do you hope to benefit from care in the office? What are your immediate goals?

- 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

How do you hope to benefit from care in this office in the long run? What are your long-term goals?

- 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

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

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 unimpeded health? _____

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 allow us to help you to better participate in a program of care specifically focused on your spine, your nervous system, and your overall health and wellness.

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 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 and help me to feel the difference in my body.

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: _____

Signature: _____ Date: _____

Copies: _____