



Network Care Center

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HEALTH PROFILE

Appt Date: _____

Last name: _____ First name: _____
 Address: _____ City: _____ Prov. _____ Postal
 code : _____ Phone (home): _____ work: _____
 cell: _____ E-mail: _____ Status: M S D W
 Date of birth (d/m/y) _____ # Of Children: _____ Occupation: _____
 Family Doctor: _____ Doctor's Phone _____ Dr.'s
 Address: _____
 How did you discover our office and the professional services we offer? _____

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

Do you have a current health concern? Please describe: _____

When did this situation or concern begin? _____

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

If yes, what were you told? _____

What was done? _____

Did it seem to work? _____

Please grade the level to which this health concern affects these aspects of your life

X = does not affect me

1 = affects me somewhat

2 = affects me moderately

3 = affects me drastically

___ effect on work

___ effect on social life

___ effect on exercise

___ effect at nighttime

___ effect during the daytime

___ effect on recreation/play

___ effect on walking

___ effect on eating

___ concern about health

___ concern about particular symptom/condition

___ effect on rest/sleep

___ effect on sleeping

___ effect on love life

Is there anything that makes this concern worse? _____

Is there anything that makes this concern better? _____

Why do you think this is happening or continues to happen to you? _____

If this symptom were to go away tomorrow what would be different about your life? _____

What are you doing in your life now that is different than if you did not have this concern?

Please mark the statement that you feel best describes your current feelings about yourself and your situation.

I feel helpless, like little or nothing works

I feel terrible, really bad, I am scared, and hope that you can fix me.

I feel stuck, and I can't help myself right now.

I deserve more than what I've been experiencing, and would like you to assist me in my healing.

Physical History

Each of these has potential to stress your nervous system. Please indicate which plays a role in your life either presently or in the past.

	Mild		Moderate		Extreme	
	Past	Present	Past	Present	Past	Present
Falls	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sports impacts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical fights	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical/sexual abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Repeated postural stress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Childhood injuries/Falls	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Motor Vehicle Accidents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please check yes or no to the following questions. If you check yes, please explain.

Have you ever been knocked unconscious? Yes no _____

Have you ever used crutches, a cane or a walker? Yes no _____

Have you ever broken any bones? Yes No _____

Have you ever had an impact, fall or jolt that may have injured your spine? Yes No _____

Have you ever been hospitalized? Yes No _____

Have you had surgery? Yes No _____

Have you had? Spinal x-rays Cat scans MRI imaging Spinal brace Neck collar
 Heel lift Orthotics Traction Spinal Tap Traction

During the day do you sit stand Do phone work do deskwork
drive walk mechanical work heavy lifting

Chemical History

Please grade any dietary selection that is appropriate for you using the following scale

X = do not consume this

1 = consume this rarely

2 = consume this weekly

3 = consume this daily or more

___ alcohol	___ fried foods	___ beef
___ coffee	___ cooked, canned vegetables	___ poultry
___ tobacco	___ dairy (milk products)	___ fish
___ artificial sweeteners	___ eggs	___ seafood
___ soft drinks	___ whole grains	___ fasting
___ diet food	___ fruit	___ organic foods
___ refined sugar	___ raw vegetables	___ vitamins/ supplements

Do you or did you work with any chemical, fume, dust, powder, smoke etc. for long periods?

Please list any medications you are presently using _____

Please list any herbs, nutritional supplements or natural remedies you take regularly _____

Emotional History

	Mild		Moderate		Extreme	
	Past	Present	Past	Present	Past	Present
Childhood stress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
School stress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Family stress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Relationship stress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stress of being sick	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stress of a loved one being sick	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Work related stress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stress of commuting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of a loved one	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Change in life-style	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Change in career	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Abuse(emotional/physical/sexual)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

When you are stressed, how do you "Center" yourself or "Re group" ? _____

Previous Therapeutic Modalities

Have you had experience with any of the following health, treatment or healing modalities? If so, please describe when you went, for how long you went and the results:

- Ayurvedic medicine _____
- Bodywork/ Massage _____
- Breathwork _____
- Emotional Therapy/ Psychotherapy _____
- Homeopathy/ Herbalist _____
- Meditation/ Prayer _____
- Movement/ Exercise _____
- Music/ Sound/ Light/ Aromatherapy _____
- Nutritional Counseling/ Therapy _____
- Oriental Medicine/ Acupuncture _____
- Osteopathy/ Cranial Work _____
- Somato Respiratory Integration _____
- Yoga/ Movement/ Dance/ Tai Chi/ Chi Gong _____
- Other: _____

Has your spine ever been professionally adjusted? Yes No

How long ago? And by whom? _____

Why did you go? _____

Are you still going? _____

Were you pleased? _____

Does your family receive Chiropractic care? _____

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

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