Network Care Center

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	☐	☐	☐	☐	☐	☐
Sports impacts	☐	☐	☐	☐	☐	☐
Physical fights	☐	☐	☐	☐	☐	☐
Physical/sexual abuse	☐	☐	☐	☐	☐	☐
Repeated postural stress	☐	☐	☐	☐	☐	☐
Childhood injuries/Falls	☐	☐	☐	☐	☐	☐
Motor Vehicle Accidents	☐	☐	☐	☐	☐	☐

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
___coffee
___tobacco
___artificial sweeteners
___soft drinks
___diet food
___refined sugar
___fried foods
___cooked, canned vegetables
___dairy (milk products)
___eggs
___whole grains
___fruit
___raw vegetables
___beef
___poultry
___fish
___seafood
___fasting
___organic foods
___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	☐	☐	☐	☐	☐	☐
School stress	☐	☐	☐	☐	☐	☐
Family stress	☐	☐	☐	☐	☐	☐
Relationship stress	☐	☐	☐	☐	☐	☐
Stress of being sick	☐	☐	☐	☐	☐	☐
Stress of a loved one being sick	☐	☐	☐	☐	☐	☐
Work related stress	☐	☐	☐	☐	☐	☐
Stress of commuting	☐	☐	☐	☐	☐	☐
Loss of a loved one	☐	☐	☐	☐	☐	☐
Change in life-style	☐	☐	☐	☐	☐	☐
Change in career	☐	☐	☐	☐	☐	☐
Abuse(emotional/physical/sexual)	☐	☐	☐	☐	☐	☐

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:

- ☐ Ayervedic 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?______________________________