# Comprehensive Health Profile

Dr. Angela Smith 111 Sherwood Drive, Suite 208, Ottawa, ON K1Y 3V1 (613) 355-0785

Today's Date: _____

Name: _____ Address: _____
P.O. Box: _____ City: _____ Province: _____ Postal Code: _____
Home Ph: _____ Cell: _____ Bus. Ph: _____
Email Address: _____ M ___ F ___ DOB: _____ Age: _____
Mar./Rel. Status: _____ No. of Children: ____ Occupation: _____
Employer: _____
How did you hear about this office? _____
May we thank the person who referred you? Yes No Name: _____

Please complete this health history survey, as it will provide information to better understand your history, your present and long term needs and any past or current compromise to your health, wellness, or quality of life.

## Part I: Your Health Concerns or Symptoms and How They Affect You

Reason for today's appointment: □ Increased Health □ Specific condition or problem
□ Family check-up □ Other: _____

If you currently have a specific condition, problem, or concern, please describe: _____
_____
_____

When did this begin? _____
Have you done anything about this situation? Yes No
If yes: What did you do? _____
Who did you see? _____
What were you told? _____
What was done? _____
What were your desired results? _____ Did you get those results? _____
How did your situation change after treatment? _____

How does this problem affect your: (Circle your response, add comments as needed)

| | | | | | |
|---|---|---|---|---|---|
| Work: | Not at all | Slightly | Moderately | Severely | _____ |
| Relaxation: | Not at all | Slightly | Moderately | Severely | _____ |
| Sitting: | Not at all | Slightly | Moderately | Severely | _____ |
| Walking: | Not at all | Slightly | Moderately | Severely | _____ |
| Exercise: | Not at all | Slightly | Moderately | Severely | _____ |
| Sports: | Not at all | Slightly | Moderately | Severely | _____ |
| Social Life: | Not at all | Slightly | Moderately | Severely | _____ |
| Love Life: | Not at all | Slightly | Moderately | Severely | _____ |
| State of Mind: | Not at all | Slightly | Moderately | Severely | _____ |
| Mood: | Not at all | Slightly | Moderately | Severely | _____ |

Other: _____

How concerned are you about this problem? Now: Not at all Slightly Moderately Severely
In the Past: Not at all Slightly Moderately Severely

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

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## Part II: Health/Trauma/Medical/Chiropractic and Healing History

1. Have you ever injured your spine, neck, head, back, ribs, or hips? Yes No
   a) Date of **most significant** injury: _____
   b) What happened? _____
   c) Date of **most recent** injury: _____
   d) What happened? _____
   e) Did you recover from the injuries? Yes No
   f) Please explain: _____
2. Have you ever injured your shoulders, arms, hands, legs, or feet? Yes No
   a) Date of **most significant** injury: _____
   b) What happened? _____
   c) Date of **most recent** injury: _____
   d) What happened? _____
   e) Did you recover from the injuries? Yes No
   f) Please explain: _____

3. Have you had a work/vehicular accident related injury? Yes No
4. Please list medications (prescription or non-prescription) you have taken within the past 60 days:
   _____
   _____
5. In the past, have you taken other medication for a period of more than three months? Yes No
   a) What did you take? _____
   b) What was the reason for taking this medication? _____
6. Have you had any spinal X-rays, Cat scans or MRI of your spine, head, neck, back, hips, or limbs? Yes No
   a) When? _____
   b) What were you told about them? _____
   c) Where are these films and records now? _____
7. Have you had any surgeries? Yes No Please explain: _____
   _____
8. Have you broken any bones, or significantly sprained part of your body? Yes No
   Please explain: _____
9. Have you consulted a physician or other health care provider in the past 3 months? Yes No
   Please explain: _____
10. When was your last visit to a physician? _____
    a) What was the reason for the visit? _____
    b) What was done or suggested? _____
11. Have you ever been to a chiropractor? Yes No
    a) Why did you go? _____
    b) When did you stop going? _____
    c) Why did you stop going? _____
12. Please circle any of the following health, treatment, or healing approaches you have experienced:

| | | |
|---|---|---|
| Massage | Physiotherapy | Homeopathy |
| Acupuncture | Yoga | Osteopathy |
| Chelation Therapy | Other(s): _____ | |

13. Please list any herbs, nutritional supplements or natural remedies you take regularly: _____
_____
14. Do you have an exercise, meditation, prayer or nutritional/dietary program? Yes No
Please describe: _____
15. When stressed, how do you "center yourself" or "re-group"? _____
_____
16. How would you rate your current level of resilience (ability to 'bounce back' from illness, injury, stress, or overload, and ability to naturally fight infections and illness)? (circle one)
Very Low Low Average High Very High Unsure

## Part III: Stress Survey

Please indicate any of the following stresses you have experienced.
CIRCLE for current, Underline for past

Physical: Falls Accidents Difficult Birth Physical Abuse Broken Bones Sports
Postural Stress Computer Work Long Drives Lifting Bending
Carrying Standing/Sitting for Long Periods Other:_____

Mental and Emotional: Loss of Loved Ones Family Stress Financial Concerns
Divorce/Separation Work Stress Move of Home/School
Emotional or Sexual Abuse Change in Career Fast-paced Life
Internalized Feelings Quick Temper Perfectionist Procrastination
Other:_____

Chemical: Smoking Second Hand Smoke Medications Fumes Junk Food
"Recreational" Drugs Environmental Artificial Sweeteners Refined Sugar
Alcohol Other:_____

## Part IV: Your Specific Needs and Hopes for Help in This Office

1. What are the aspects of your life that very much please you, bring you joy, or help you feel better about yourself? _____
_____

2. Describe the particular factors or elements about your life, experiences, family, work, recreation, past injuries, genetics, dietary habits, exercises, outlook, etc. that you feel impair your opportunity for full expression of health: _____
_____

3. Is there anything else that may help to understand you, your history, or your needs that has not been discussed on this survey? Yes No
Please explain: _____
_____

Network Spinal Analysis is a lifestyle and a family affair.
It is our policy that all parents have their children examined.

Thank you for choosing this office for your health and well-being. I look forward to helping you in your healing process and assisting you in your journey to a greater quality of life.

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# Physical Symptomatic Questionnaire

**Please answer the following questions ONLY with respect to your MOST important concern:**

**In what part of your body do you experience your pain/symptoms?**

_____

**Does your pain/symptom travel to anywhere else in your body? Y N**

**If Yes, where?**_____

**What does this pain/symptom feel like? Please check any that apply:**

**Sharp Stabbing Dull Achy Numbness Tingling Burning**
**Cold Pins & Needles Electricity Other (specify): _____**

**When did this pain/symptom begin?** _____

**What happened?** _____

**How has the pain/symptom changed over time? Worse Better No Change**

**How often does this pain/symptom occur?** _____

**When your pain/symptom is present, how long does it last?** _____

**On the scale below, please mark the level of pain you most consistently feel, with 0 being no pain and 10 being the worst pain you can imagine.**

**|_____|**
**0 10**

**What makes this pain/symptom better?**

_____

**What makes this pain/symptom worse?**

_____

**Are there any other related or associated concerns?**

_____

**Have you ever experienced this pain/symptom or something similar in the past? Y N**

**If Yes, please describe**

_____