Comprehensive Health History

Please complete this personal history survey, as it will provide your Network Practitioner with important information to better understand your history, your present and longer term needs, and any compromise to your wellness or health related to the quality of life that you may now be experiencing.

Today's Date: _____
Please check your reason(s) for seeking care:
Pain relief_____ Stabilization_____ Family Health/Prevention____ Doctor's Advice____
Personal Data
Name _____ Date of Birth: _____ S M D W
Address_____
Street City State Zip Code

Home Phone#: (_____)_____ Cell Phone#(_____)_____ (Circle preferred) Email
_____ **SSN: _____-_____-_____**
Height: _____ Weight: _____ Preferred Pronoun: _____
Emergency Contact: _____ Phone: _____

Are you currently pregnant? Yes No **If yes, what is your due date? _____**
Whom may we thank for referring you to Embodied Chiropractic? _____

Occupation:_____Employer: _____
Work Phone _____ May we contact you there if needed? Y N
Do you enjoy what you do? Y N Duties/ Habits: ____ sit more than 1 hour

Part I:Your Health Concerns or Symptoms and How They May Affect Your Life

1. What would you like to receive from this office? _____

_____

2. Do you have any current health or spinal concerns? If so, please describe: _____

_____

3. Has this ever happened before?_____
4. Have you done anything about this concern or gotten any advice or treatment for it? Yes No
   If yes, what were you told? _____
5. What was done? _____
6. Did it seem to work? _____
7. What was different about ***you*** after treatment? _____
8. What was different about ***your condition or symptom*** after treatment?_____

_____

9. What was different about ***your concern about the condition or symptom*** after treatment?

_____

Please grade the level to which this concern(s) affects these 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 on work 0 1 2 3	Affect on recreation/exercise 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 on sitting 0 1 2 3
Affect on family life 0 1 2 3	Affect on eating 0 1 2 3	Affect on love life 0 1 2 3
Concern about particular symptom/condition 0 1 2 3		Concern about Health 0 1 2 3

Comments: _____

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

a) What did he/she do about them? _____

b) Did it seem to work? _____

10. How aware of this are you during the day? 0 1 2 3 at night? 0 1 2 3

11. Is there any time, or activity you can be involved with when you totally or almost totally forget about this condition, symptom or concern about this? _____

_____

12. Is there any time of day or activity which makes you more aware of it? _____

_____

13. Why do you think this has happened or continues to happen to you? _____

_____

14. Do you think this is the sole cause? ❒ Yes ❒ No

If no, what else is involved? _____

15. If this condition or symptom were to go away tomorrow, what would be different about your life? _____

16. What are you doing in your life now that is different than if you did not have this condition / symptom? _____

17. Since this happened, have you changed any habits? _____

18. Which best describes your current feeling about yourself and your situation? (Please circle the letter that best applies.)

a) I feel helpless, like little or nothing works.

b) This is terrible, really bad, I am scared, and hope you can fix it for me.

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

d) I deserve more than what I have been experiencing, and would like assistance in my healing.

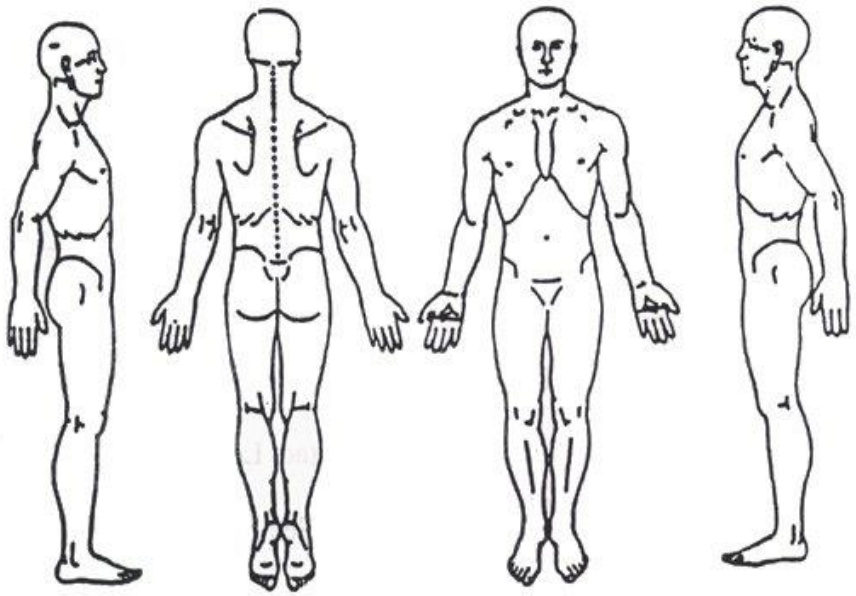
e) Anything else? _____

19. Please grade the following on a scale of 0 to 3: **0 - not at all 1 - slight 2 - moderate 3 -extreme**

a) Currently, how inconvenient is your situation, condition or symptom? 0 1 2 3

b) How inconvenient was it in the past? 0 1 2 3

Body diagram: mark where your body is affected



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

1. Have you **ever** injured your spine (neck, head, back, hips)? ❒ Yes ❒ No
   a) Date of **most significant** injury: _____
   b) What happened? _____
   c) Date of **most recent** injury: _____
   d) What happened? _____
2. Please list medications (prescription or non prescription) you have taken within the past 60 days: _____
3. In the past, have you taken other medications for a period of more than 3 months?
   ❒ Yes ❒ No
   a) What did you take? _____
   b) What was the reason for taking this medication? _____
4. Have you had any spinal X-rays, CAT scans or MRI imaging of your spine (neck, head, back, hips)? ❒ Yes ❒ No
   a) When? _____
   b) What were you told about them? _____
5. Have you had any surgeries? ❒ Yes ❒ No
   Please explain: _____
6. Have you broken any bones, or significantly sprained part of your body? ❒ Yes ❒ No
   Please explain: _____
7. Please list any herbs, nutritional supplements or natural remedies you take regularly:
   _____
8. Have you consulted a physician or any other health care provider in the past three months? ❒ Yes ❒ No
   Please explain: _____
   _____

9. Have you had a work and/or auto collision related injury? ❒ Yes ❒ No

If so, please describe: _____

10. Has your spine ever been professionally adjusted? ❒ Yes ❒ No

a) By whom and when? _____

b) Why did you go? _____

c) What did he/she do for you? _____

d) Were you pleased? ❒ Yes ❒ No

e) Are you still going? ❒ Yes ❒ No

f) Does your family receive chiropractic care? ❒ Yes ❒ No

11. Do you consult with a physician or any other health care provider for other than routine evaluations? ❒ Yes ❒ No

a) What is the reason for the visit(s)? _____

b) When was your last visit? _____

c) What has been done or suggested? _____

12. **Please describe your sleep habits:**

a) **Do you sleep**: ❒ Heavily ❒ Moderately ❒ Lightly

b) **When you awaken, do you:** ❒ Wake up with difficulty and only come to consciousness after some time ❒ Wake up easily and fully alert

c) **Please check the boxes that apply to sleep difficulties:**

❒ Falling asleep ❒ Staying asleep ❒ Sleeping with others in the room

❒ Sleeping with sound/noise around me ❒ Sleeping with the lights on

❒ I need white noise to sleep ❒ I have no difficulty sleeping

13. **Please rate the following on a scale of 5 to 1 with 5 best describing you and 1 least describing you:**

Feeling safe in my life is important to me.	5 4 3 2 1
Constancy or knowing what is going to happen next is important to me.	5 4 3 2 1
I am comfortable expressing my emotions.	5 4 3 2 1
I am easily influenced by the emotions of others.	5 4 3 2 1
My schedule and plans are important to me.	5 4 3 2 1
I find rules, stories, facts and details easy to deal with.	5 4 3 2 1
I have definite rules about how things should be.	5 4 3 2 1
When something bothers me, it's difficult to let it go.	5 4 3 2 1
Being correct is important to me.	5 4 3 2 1
I am easily distracted.	5 4 3 2 1
Having a deeper meaning of life is very important to me.	5 4 3 2 1
I often fear that the tasks that need to be done will not be accomplished on time.	5 4 3 2 1
I often trust that what needs to be done will be done.	5 4 3 2 1
There are times when I become what others expect me to be rather than being myself.	5 4 3 2 1
I have a strong sense of who I am and what is important in my life.	5 4 3 2 1

14. When I remember the past, I recall the upside _____% and the downside _____% of the time.

15. Do you have an exercise, meditation, prayer, nutritional, and/or dietary program? ❒ Yes ❒ No

If yes, please describe: _____

16. When stressed, how do you "center yourself" or "re-group"? _____

_____

Part III: Stress Survey:

Please check whether you are experiencing the following stress situations currently, in the past, or both.

	Past			Current		
	Mild	**Moderate**	**Extreme**	**Mild**	**Moderate**	**Extreme**
Childhood stress	❒	❒	❒	❒	❒	❒
School stress	❒	❒	❒	❒	❒	❒
Play or recreational	❒	❒	❒	❒	❒	❒
Family stress	❒	❒	❒	❒	❒	❒
Personal relationships	❒	❒	❒	❒	❒	❒
Stress of being sick	❒	❒	❒	❒	❒	❒
Work related stress	❒	❒	❒	❒	❒	❒
Stress of commuting	❒	❒	❒	❒	❒	❒
Loss of loved one	❒	❒	❒	❒	❒	❒
Change in lifestyle	❒	❒	❒	❒	❒	❒
Change in vocation	❒	❒	❒	❒	❒	❒
Abuse	❒	❒	❒	❒	❒	❒

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

In a published study conducted within the Medical College at the University of California, Irvine, over 2,800 people receiving Network Care reported results showing an overall improvement in all of the categories of health and wellness listed below.

Use this scale rating each of the categories in question 1:

a) very important to me b) important to me c) not so important to me d) does not apply

1. What is ***currently*** of interest to you?
   _____ Improvement of my physical symptoms
   _____ Improvement of my emotional/mental symptoms
   _____ Improvement of my ability to react or respond to stress
   _____ Improvement in enjoyment of life and the ability to make constructive choices
   _____ Overall improved quality of life
2. What aspect of your life **brings you joy**, or helps you feel better about yourself?_____

   _____
3. What aspect of your life **challenges you**, interferes with your ability to heal or feels like you have no control over?

4. What aspect of your life do you excel at, **have strength in**, or that gives you an edge in moving through challenges? _____

5. When communicating to you about your care: (circle your preference)

a) Mostly speak with me about the clinical findings and tell me about 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, help me to feel the difference in my body.

6. 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:

_____

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

Women Only: *Please fill out the following questions regarding your own pregnancies/birth*
Miscarriage or Abortions: Y N Please explain:_____
Are you taking birth control? Y N
Past Deliveries: *(Check regarding most recent delivery; explain all deliveries)*
Third trimester presentation: Vertex____ Breech____ Transverse___Face/Brow___
Type or birth: Vaginal _____ Forceps_____ Suction cup/Vacuum_____
Cesarean_____ Hospital_____ Home_____
Interventions: Pitocin_____ Epidural_____ Episiotomy_____
Delivery Location:_____OB/Midwife_____
Pregnancy & Birth Story:
_____
_____
_____
_____

Current Pregnancy:
Do you plan on delivering at:(circle) Home Birthing Center Hospital
Birthing location: _____
Do you plan on using a: (circle all that apply) Midwife Doula Nurse Midwife OB
Names:_____
Do you plan on vaccinating? Yes No
If yes, what schedule are you choosing: Full Delayed Modified
Please explain?
_____

We offer many payment options in an attempt to keep down prices and minimize your time at each visit. Please check which you prefer from each list. This information does not commit you to anything; it serves only to help us assist you better.

Payment Frequency:	**Type of Payment:**	**If using a Card:**
___ Pay at each visit	___ Credit or Health Savings Card	___ Pay in person
___ Pay ahead with a discount	___ Check or Cash	___ Auto-pay with a card on file

Participant Consent Form

When a participant seeks chiropractic health care and we accept a participant for such care, it is essential for both to be working toward the same objectives. It is important that each participant understand both the objectives and the methods that will be used to attain said objectives. This will prevent any confusion or disappointment. You have the right, as a participant, to be informed about the condition of your health and the recommended care and management to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks and alternatives.

Chiropractic *is a science, art and philosophy that concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may affect the restoration and preservation of health.*

Health *is a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity. Therefore, symptoms are NOT a valid measure of health.*

Subluxation *is the physical manifestation of an un-integrated life experience. When one or more of the 24 vertebrae of the spinal column are misaligned, the system as a whole is affected: structurally, chemically, and tonally. This results in interferences to nerve system function, leading to tightened muscles and taught ligaments, therefore leading to a decrease in the body's overall, healthy performance.*

Subluxations are corrected and/or reduced by an ***adjustment.*** *An adjustment is the specific application of forces to correct and/or reduce subluxation. Our chiropractic method of correction is by specific adjustments of the spine and related structural components. Adjustments are usually done by hand but may be performed by handheld instruments or specialized tables.*

If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

I will call the office if I have any questions or if any problems arise before each scheduled follow-up visit. I have read and understand all of the above statements.

_____ _____

Signature *Print Name*

_____

Date