COMPREHENSIVE HEALTH PROFILE

WELLSPRING
Center for Wellbeing

Last Name:_____ **First Name:**_____ **Date:**_____

Address: _____**City:** _____ **State:**____ **Zip Code:**_____

Date of birth:_____**Occupation:**_____**Marital Status: S M D W**

Best Phone H W C:_____**Alternate Phone H W C:**_____

Email:_____**Who referred you to our office:**_____

Please complete this personal history survey, as it will provide your Network Practitioners 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.

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

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

2. Why is this important to you? _____

3. What are your top concerns about your health and/or life, whether it be physical, emotional, mental, or other? _____

4. When did this / these situation(s) or concern(s) begin? _____

5. Have you done anything about this concern or gotten any advice or treatment for it? ❒ Yes ❒ No
   If yes, what were you told? _____

6. What was done? _____

7. What was your experience? _____

8. 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. **2 - It seems to moderately affect me.**
   1 - It seems to slightly 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) What was their experience? _____

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

10. 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? _____

11. Is there any **time of day** or **activity** which makes you **more aware this challenge(s)**? _____

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

13. Do you think this is the sole cause? ❒ Yes ❒ No
    If no, what else is involved? _____
14. If this condition or symptom were to go away tomorrow, what would be different about your life? What would you be doing more of? _____
15. What are you doing in your life now that is different than if you did not have this condition / symptom?
    _____
16. Since this happened, have you **changed any habits**? _____
17. 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

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 feels **awful**, it hurts, I am scared, and hope you can fix it for me.
    c) I feel frustrated, **stuck**, and need help to get past this.
    d) I know **I deserve more** than what I have been experiencing, and would like assistance in my healing.
    e) Anything else? _____

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. For what **reason** are you taking them? _____
4. **How long** have you been on each? _____
5. **What has changed** since you have taken this medication (s)? _____
6. How long you do **plan** to be on each medication? _____
7. 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 and what effect did it have? _____
    _____
8. 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 was your experience? _____
    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
I can sometimes **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: _____

_____

Part III: Stress Survey:

Please check whether you are have or 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	❒	❒	❒	❒	❒	❒

1. From the stress survey above, which specific events or experiences in your life stick out the most? _____

_____

2. How did these contribute to "what" stresses or triggers you in your body/life? _____

_____

3. How does this show in how you live and see the world today?_____

_____

4. What current ways do you center yourself and create more ease? (body, emotion, mind, heart)

_____

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

Thank you for taking this time to answer questions about the most important person in your world…YOU. Without your health and wellbeing, how much energy will you have to care for the ones you love? How may they be impacted?

Now that you have taken inventory on how life is showing up in your body, what is most important for us to help you with?

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? _____

We understand the demands that today's world brings and the impact it has on your body's capacity to heal, be well and thrive. We are also ***passionate about helping families and communities thrive.***

Please accept our invitation to: ***Bring your family members in within the same week that you are seen, and we will GIFT them their FIRST 2 VISITS ($220 value).***

Thank you for choosing Wellspring Center for Wellbeing. We are excited you are here!