COMMUNITY CHIROPRACTIC WELLNESS CENTER

COMPREHENSIVE HEALTH PROFILE

Michael A. DeFino, DC

Last Name: ______________________First Name:________________________ Today's Date:__________________

Address:______________________________City:__________________________State:_______Zip:___________

HomePhone#:________________________Work/AlternatePhone#:________________________DOB:__________

Age:___________Occupation:__________________________E-mail address:________________________________

Would you like to receive our e-mail newsletter?____

Who referred you to this office?____

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

Part 1: Your Health Concern or Symptoms and How They May Effect Your Life

1. Do you have a current health concern? If so, please describe.____

____

2. When did this situation or concern begin?________________________________

3. Have you taken any action regarding this concern or gotten any advice or treatment for it? Yes No

If Yes, what were you told? _____________

____

4.What was done?____

5. Did it seem to work?____

6. What was different about you after treatment?_____________________________

7. What was different about your condition after treatment?___________________

____

8. Please grade the level to which this health concern(s) affects these aspects of your functioning/quality of life.

0-Does not seem to affect me 1- Seems to slightly affect me

2- Seems to moderately affect me 3- Seems to drastically affect me

Effect on work 0 1 2 3 Effect on recreation/play 0 1 2 3 Effect on sleep 0 1 2 3

Effect on social life 0 1 2 3 Effect on walking 0 1 2 3 Effect on sitting 0 1 2 3

Effect on exercise 0 1 2 3 Effect on eating 0 1 2 3 Effect on love life 0 1 2 3

Concern about particular symptom/concern 0 1 2 3 Concern about health 0 1 2 3

9. Please write down your definition of health:____

____

____

____

____

Part 2: Health/Trauma/Medical/Chiropractic and Healing History:

1. Have you ever injured your spine (neck, head, back, hips)?
   a) Date of *most significant* injury:____
   b) What happened?____
   c) Date of *most recent* injury:____
   d) What happened?____

2. Have you taken any medications (prescription or non-prescription) within the last 60 days? Yes No

If yes, please list them:____

3. In the past, have you taken any other medications for a period of more than 3 months? Yes No
   a) What did you take?____
   b) What were the reasons for taking them and for how long did you take them?________________
   ____

4. Have you had any spinal X-rays, CT scans or MRI imaging of your spine)neck, back, hips)?_______
   When?_____________________________Why?____

5. What were you told regarding them?____

6. Where are the films now?____

7. Have you had any surgeries? Please explain?____

8. Have you broken any bones, or significantly sprained a part of your body? Yes No
   Please explain:____

9. Please list any herbs, nutritional supplements or natural remedies you take regularly:_____________

____

10. Have you consulted a physician, or any health care provider within the past 3 months? What for?___________

____

11. Has your spine ever been professionally adjusted/manipulated/entrained? Yes No

Please explain:____
   a) By whom and when?____
   b) Why did you go?____

c) Are you still going?____

d) What did he/she do for you?____

e) Did you feel it worked/were you pleased with the results?_________________________________

12. Do you consult with a physician for anything other than routine evaluations? Yes No

13. *What is/was the reason for the visit(s)?*____

14. *When was your last visit?*____

15. *What was done or suggested?*____

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

Massage/Bodywork____

Emotional Therapy/ Psychotherapy____

Musis/Dance/Sound/Light/Aromatherapy____

Homeotherapy/Herbalist____

Ayurvedic Medicine____

Oriental Medicine/ Acupuncture____

Nutritional Counseling/ Therapy____

Oxygen Therapy/Chelation Therapy____

Rebirthing/Breath work____

Yoga/Movement/Dance/Tai Chi/Chi Gong____

Somato Respiratory Integration____

Other:____

17. Do you have an exercise, meditation, prayer, nutritional or dietary program? Please describe:_______________

____

18. When stressed, how do you "center yourself" or "re-group"?____

____

Part 3: Stress Survey: Please grade the following stresses in order of increasing intensity; this is over the span of your entire life, not just the present time.

0- no awareness of stress 1-slightly stressful situation

2- moderately stressful situation 3- extremely stressful situation

1) Overall physical stress/trauma: Includes: falls, accidents, injuries, repeated postural stress impacts, difficult birth, traction, and physical abuse. 0 1 2 3

2) Overall emotional/mental stress: Includes: loss of loved ones, rapid change in life situation, mental, emotional, or sexual abuse, legal concerns, financial concerns, move of home/school, separation/divorce etc. in relationship, stress of being ill etc. 0 1 2 3

3) Overall chemical stress: Includes: drugs, smoke, fumes, food additives, pollution, prescription drug use etc. 0 1 2 3

4) Have you ever been in a work or vehicle related injury? Please describe:_______________________________________

____

Additional Comments or things that you feel Dr. DeFino should know:____

____

____

____

____

____