

Comprehensive Health Profile

Date: ____ / ____ / ____

Name: _____ Address: _____

City: _____ State: _____ Zip: _____ Occupation: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Date of Birth: _____ Age: _____ Height: _____ Weight: _____ Marital Status: S M W D

Employer: _____ Spouse Name: _____ Employer: _____

Number of Children: ____ Social Security Number: _____ Insurance: _____

Whom may we thank for referring you to our office? _____

PLEASE ANSWER THE FOLLOWING QUESTIONS ABOUT YOUR PERSONAL HISTORY

1) Please describe your current health concerns: _____

2) Please grade and circle the level to which this health concern(s) affects the following aspects of your functioning/quality of life.

0 – It does not affect me.

1 – It slightly affects me.

2 – It moderately affects me.

3 – It drastically affects me.

Affect on Work	0 1 2 3	Affect on Recreation	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 Exercise	0 1 2 3	Affect on Eating	0 1 2 3	Affect on Love Life	0 1 2 3
Concern of Condition	0 1 2 3	Concern of Health	0 1 2 3		

3) Have you sought treatment for this situation or concern? Yes No If yes, what were you told? _____

4) What was done? _____ Did it seem to work? _____

5) What was different about **YOU**, after treatment? _____

6) What was different about your **CONDITION** or **SYMPTOM** after treatment? _____

7) Why do you think this has happened (or continues) to happen to you? _____

Do you think this is the sole cause? Yes No If no, what else is involved? _____

8) How do you feel about your current condition? (Please choose **ONE** that **BEST** describes how you feel)

- I feel helpless; nothing works.
- I don't like what I am feeling, and I hope you can fix it.
- I feel this is a pattern that has happened to me before; it is back again.
- I feel there is a message my body is giving me.
- I am afraid this might turn into another even more serious health condition.
- I am serious now about getting this problem under control.
- I don't know how I feel. I am too preoccupied with my present condition.
- I am looking for something to help me enhance my quality of life and further enhance my wellness.

9) What do you hope to receive from care in this office? _____

OVERALL STRESS SURVEY

Please grade your Current Life Stresses using the following scale:

0 - No stress 1 - Slightly stressful 2 - Moderately stressful 3 - Extremely stressful

- A) **Overall Physical Stress/Trauma:** Includes: falls, accidents, injuries, repeated postural stress, impacts, difficult birth, physical abuse, loss of consciousness, broken/fractured bones, etc.
0 1 2 3
- B) **Overall Emotional/Mental Stress:** Includes: loss of loved ones, rapid change in life situations, abuse, move of home/school, legal concerns, financial concerns, divorce, relationships, etc.
0 1 2 3
- C) **Overall Chemical Stress/Trauma:** Includes: prescription drugs, smoke, alcohol, caffeine, fumes, food additives, anesthesia from surgery, over-the-counter medications, etc.
0 1 2 3

The Following Questions Have To Do With Brain Stem Function:

A. HIGH IML

- Are you sensitive to light or have blurring vision?
- Have you experienced an increase in sweating?
- Do you have trouble sleeping, continuously waking up during the night or trouble getting to sleep?
- Do you have a history of urinary tract infections?
- Have you experienced visual changes before migraine headaches?

B. LOW IML

- Do you fatigue easily?
- Do you have cold hands or feet?
- Do you experience frequent urination or are you unable to control urinary or bowel movements?
- Do you have episodes of fainting or hypoxia?

For the next several questions please answer briefly and give the dates each began and if you can think of what contributed to it.

- Noticeable changes in your handwriting?
- Changes in sexual function?
- Are you more irritable or angry?
- Episodes of depression or anxiety?
- Problems with equilibrium, loss of balance, tripping, dropping things, etc?
- Difficulty scanning pages while reading a book?
- Difficulty adding or subtracting?
- Difficulty moving your eyes? Or double vision?
- Difficulty expressing what you would like to say?
- Any changes in speech?
- Any changes in sensation?
- Any changes in memory?
- Any changes in hearing?
- Excess dryness or wetness of the eyes or nose?

PHYSICAL HISTORY

GENERAL PHYSICAL TRAUMA:

- 1) Were you ever knocked unconscious? Yes No How/When? _____
 - 2) Have you ever broken any bones? Yes No Which Ones? _____
 - 3) Have you ever had any impacts that may have injured your head, neck, back or hips? Yes No How / When? _____
-
- 4) On average, how many hours per day do you participate in the following? Sitting Standing Desk Work
Phone Work Computer Work Driving Lifting Heavy Objects Manual Labor Stooping/Bending/Kneeling

SPORTS OR LEISURE:

- 5) Were you, or are you active in any sport(s)? Yes No Which? _____
- 6) Have you been hurt in any of these activities? Yes No Where? _____

AUTOMOBILE ACCIDENTS:

- 7) Have you, (even as a passenger), been involved in a car accident, or near collision? Please list approximate dates and severity (Mild, Moderate, Extreme). Automobile: _____
Bus, bicycle, motorcycle, train, airplane, moped, or other vehicles: _____

MEDICAL TREATMENT:

- 8) Have you ever been hospitalized? Yes No If yes, what was done to you? _____
- 9) Have you had surgery? Yes No If yes, what was done to you? _____
- 10) Do you have all of your body parts? Yes No If no, please describe: _____
- 11) Have you ever had: Spinal Injections Physiotherapy Traction Heel Lifts Diagnostic X-Rays Acupuncture
Chemotherapy Transfusion Nutrition Evaluation Body Part Immobilized

CHEMICAL HISTORY

GENERAL CHEMICAL INFORMATION:

- 1) Do you take herbs/vitamins/homeopathy? Yes No Please describe: _____
- 2) Are you taking any drugs or medication regularly? Please list drugs and reasons for taking them: _____
- 3) Do you now, or in the past have a history of alcohol / drug abuse or heavy use? Yes No Please describe: _____
- 4) Do you or did you work with any chemical, fume, dust, powder, smoke for prolonged periods? Yes No
- 5) Do you have allergies/sensitivities? Yes No Please describe: _____
- 6) Please indicate how much of the following products you consume:
Alcohol - Drinks/Week: _____ Coffee – Cups/Day: _____ Tobacco – Amount/Day: _____
Artificial Sweeteners Yes No Soda - #/Day: _____ Refined Sugar – Candy/Pastries/Day: _____

EMOTIONAL HISTORY

GENERAL EMOTIONAL STRESS:

With each of the following potential stress situations, please indicate the severity either past or current.

Potential Spinal Stress/Tension Sources	PAST			CURRENT		
Childhood Stress	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Extreme	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Extreme
School Stress	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Extreme	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Extreme
Family Stress	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Extreme	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Extreme
Personal Relationships	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Extreme	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Extreme
Stress of Being Sick	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Extreme	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Extreme
Work Stress	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Extreme	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Extreme
Stress of Commuting	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Extreme	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Extreme
Loss of Loved One	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Extreme	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Extreme
Change in Lifestyle	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Extreme	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Extreme
Change in Vocation	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Extreme	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Extreme
Abuse (Verbal, Physical, Emotional, Sexual, etc)	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Extreme	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Extreme

YOUR SPECIFIC NEEDS AND HOPES FOR HELP IN THIS OFFICE

1) How do you hope to benefit from care in this office? Please rate the following:

1: Very important to me 2: Important to me 3: Not so important to me 0: Does not apply

- a) ____ Improvement of my **Physical Symptoms**.
- b) ____ Improvement of **Attitude**.
- c) ____ Improvement of my **Ability to Respond to Stress**.
- d) ____ Improvement in **Enjoyment of Life**
- e) ____ Improvement to making **Healthier, more Constructive Choices**.
- f) ____ Overall improvement in **Quality of Life**.

2) How have others been affected by your health? No one is affected They tell me to do something People avoid subject

3) What are you afraid this might affect in future? Work Kids Marriage Relationships Sports Finances Future

4) Are there health conditions you are afraid this might turn into? Family Health Problems Heart disease Cancer
 Diabetes Arthritis Fibromyalgia Depression Chronic Fatigue Don't know

5) Where do you picture yourself in the next 1-3 years if your problems are not taken care of? _____

6) What would be different or better without your health problems? _____

7) What are you most concerned about your health? _____

Thank you for completing your personal information. Please bring this in with you on your first visit.

Lind Chiropractic Wellness
 1707 Lansing Ave
 Salem, OR 97301
 503-581-6846
 info@lindwellness.com