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:*** 0 1 2 3
Includes: falls, accidents, injuries, repeated postural stress, impacts, difficult birth, physical abuse, loss of consciousness, broken/fractured bones, etc.

B) ***Overall Emotional/Mental Stress:*** 0 1 2 3
Includes: loss of loved ones, rapid change in life situations, abuse, move of home/school, legal concerns, financial concerns, divorce, relationships, etc

C) ***Overall Chemical Stress/Trauma:*** 0 1 2 3
Includes: prescription drugs, smoke, alcohol, caffeine, fumes, food additives, anesthesia from surgery, over-the-counter medications, etc.

Neurological Assessment Form

Name: _____ Date: _____

❑ Are you left or right handed?	Right	Left
❑ Have you had a head injury?	YES	NO
❑ Do you currently experience or have a past history of vertigo or balance disorders?	YES	NO
❑ Do you have any ringing or pressure in the ears?	YES	NO
❑ Do you experience nausea?	YES	NO
❑ Do you find that your balance is getting worse?	YES	NO
❑ Do you have difficulties walking down stairs?	YES	NO
❑ Do you have difficulty with math problems, or remembering numbers?	YES	NO
❑ Do you find yourself searching for words frequently when you speak?	YES	NO
❑ Have you noticed your ability to concentrate is getting worse?	YES	NO
❑ Do you get lost often or have a hard time with directions?	YES	NO
❑ Do quick flashes of light on TV or loud noises bother you?	YES	NO
❑ Do you feel like you need to wear sunglasses outside?	YES	NO
❑ Has your handwriting changed in recent years?	YES	NO
❑ Do you have a hard time swallowing?	YES	NO
❑ Do you gag easily?	YES	NO
❑ Do you experience blurriness in your vision or double vision? ← (CIRCLE)	YES	NO
❑ Do you have any changes in smell or .smell foul things that are not present?	YES	NO
❑ Do you have any difficulty with taste or taste things differently than what you are	YES	NO
❑ Noticed clumsiness in hand coordination? Which hand? Right / Left (CIRCLE)	YES	NO
❑ Do you have difficulty with short-term memory?	YES	NO
❑ Have you been told or noticed any memory loss of past events?	YES	NO
❑ Noticed uneven sweating or temperature on one side of your body?	YES	NO
❑ Do you have any tightness, weakness or instability in your back or neck? ←(CIRCLE)	YES	NO
❑ Do you have tightness, or feelings of weakness in your hands or legs? ←(CIRCLE)	YES	NO
❑ Do you ever have any numbness or tingling in your hands, legs, or face? ←(CIRCLE)	YES	NO
❑ Do you have any difficulty with falling asleep or staying asleep?	YES	NO
❑ Do you get motion sickness easily (car sick or sea sick)?	YES	NO
❑ Do you ever experience flashes of light in your visual field?	YES	NO
❑ Do you ever experience dry eyes or mouth? ←(CIRCLE)	YES	NO
❑ Do you ever experience increase tearing or salivation? ←(CIRCLE)	YES	NO
❑ Do you ever have slurred speech?	YES	NO
❑ Noticed any drooping of your eyelids or facial muscles? ←(CIRCLE)	YES	NO
❑ Do you ever notice increased heart rate (tachycardia)or pulse during the day?	YES	NO
❑ Have you ever experienced or been diagnosed with arrhythmia (fluctuating heart rate)?	YES	NO
❑ Do you experience Deja Vu?	YES	NO
❑ Does driving cause you fatigue, headaches, or any other symptoms? ←(CIRCLE)	YES	NO
❑ Does working on a computer cause you fatigue, headaches or other symptoms?	YES	NO
❑ Have you lost your interest in hobbies and functions that you used to enjoy?	YES	NO
❑ Do you have a hard time motivating yourself to engage in activities?	YES	NO
❑ Do you ever have fluttering of the *eye* or noticed you are blinking frequently?	YES	NO
❑ Do you have difficulty distinguishing right and left?	YES	NO

Patient Signature: _____ Date: _____

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: _____

MEDCIAL 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	☐Mild ☐Moderate ☐Extreme	☐Mild ☐Moderate ☐Extreme
School Stress	☐Mild ☐Moderate ☐Extreme	☐Mild ☐Moderate ☐Extreme
Family Stress	☐Mild ☐Moderate ☐Extreme	☐Mild ☐Moderate ☐Extreme
Personal Relationships	☐Mild ☐Moderate ☐Extreme	☐Mild ☐Moderate ☐Extreme
Stress of Being Sick	☐Mild ☐Moderate ☐Extreme	☐Mild ☐Moderate ☐Extreme
Work Stress	☐Mild ☐Moderate ☐Extreme	☐Mild ☐Moderate ☐Extreme
Stress of Commuting	☐Mild ☐Moderate ☐Extreme	☐Mild ☐Moderate ☐Extreme
Loss of Loved One	☐Mild ☐Moderate ☐Extreme	☐Mild ☐Moderate ☐Extreme
Change in Lifestyle	☐Mild ☐Moderate ☐Extreme	☐Mild ☐Moderate ☐Extreme
Change in Vocation	☐Mild ☐Moderate ☐Extreme	☐Mild ☐Moderate ☐Extreme
Abuse (Verbal, Physical, Emotional, Sexual, etc)	☐Mild ☐Moderate ☐Extreme	☐Mild ☐Moderate ☐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 <u>most</u> 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