

Comprehensive Health Profile

Dr. Angela Smith 111 Sherwood Drive, Suite 8, Ottawa, ON K1Y 3V1 (613) 355-0785

Today's Date: _____

Name: _____ Address: _____

P.O. Box: _____ City: _____ Province: _____ Postal Code: _____

Home Ph: _____ Cell: _____ Bus. Ph: _____

Email Address: _____ M ___ F ___ DOB: _____ Age: _____

Mar./Rel. Status: _____ No. of Children: _____ Occupation: _____

Employer: _____

How did you hear about this office? _____

May we thank the person who referred you? Yes No Name: _____

Please complete this health history survey, as it will provide your doctor with important information to better understand your history, your present and long term needs and any past or current compromise to your health, wellness or quality of life.

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

Reason for today's appointment: Increased Health Specific condition or problem
 Family check-up Other: _____

If you currently have a specific condition, problem or concern, please describe: _____

When did this begin? _____

Have you done anything about this situation? Yes No

If yes: Who did you see? _____

What were you told? _____

What was done? _____

What were your desired results? _____ Did you get those results? Yes No

How did your situation change after treatment? _____

How does this problem affect your: (Circle your response, add comments as needed)

Work: Not at all Slightly Moderately Severely _____

Relaxation: Not at all Slightly Moderately Severely _____

Sitting: Not at all Slightly Moderately Severely _____

Walking: Not at all Slightly Moderately Severely _____

Exercise: Not at all Slightly Moderately Severely _____

Sports: Not at all Slightly Moderately Severely _____

Social Life: Not at all Slightly Moderately Severely _____

Love Life: Not at all Slightly Moderately Severely _____

State of Mind: Not at all Slightly Moderately Severely _____

Mood: Not at all Slightly Moderately Severely _____

Other: _____

How concerned are you about this problem? Now: Not at all Slightly Moderately Severely

In the Past: Not at all Slightly Moderately Severely

Is there any time of day or activity that makes you mostly or totally forget about this problem? _____

Is there any time of day or activity that makes you more aware of it? _____

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

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

1. Have you ever injured your spine, neck, head, back or hips?
 - a) Date of **most significant** injury: _____
 - b) What happened? _____
 - c) Date of **most recent** injury: _____
 - d) What happened? _____
 - e) Did you recover from the injuries? Yes No
 - f) Please explain: _____

2. Have you had a work/vehicular accident related injury? Yes No
3. Please list medications (prescription or non-prescription) you have taken within the past 60 days:

4. In the past, have you taken other medication for a period of more than three months? Yes No
 - a) What did you take? _____
 - b) What was the reason for taking this medication? _____
5. Have you had any spinal X-rays, Cat scans or MRI imaging of your spine, head, neck, back or hips? Yes No
 - a) When? _____
 - b) What were you told about them? _____
 - c) Where are these films now? _____

6. Have you had any surgeries? Yes No Please explain: _____

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

8. Have you consulted a physician or other health care provider in the past 3 months? Yes No
9. When was your last visit to a physician? _____
 - a) What was the reason for the visit? _____
 - b) What was done or suggested? _____

10. Have you ever been to a chiropractor? Yes No
 - a) Why did you go? _____
 - b) When did you stop going? _____
 - c) Why did you stop going? _____

11. Please circle any of the following health, treatment or healing approaches you have experienced.

Massage	Physiotherapy
Homeopathy	Acupuncture
Yoga	Osteopathy
Chelation Therapy	Other: _____

12. Please list any herbs, nutritional supplements or natural remedies you take regularly: _____

13. Do you have an exercise, meditation, prayer or nutritional/dietary program? Yes No
Please describe: _____

14. When stressed, how do you “center yourself” or “re-group”? _____

Part III: Stress Survey

Please circle any of the following stresses you have experienced in your life.

Physical: Falls Accidents Difficult Birth Physical Abuse Broken Bones
Postural Stress Computer Work Long Drives Sports
Other: _____

Mental/Emotional: Loss of Loved Ones Family Stress Financial Concerns
Divorce/Separation Work Stress Move of Home/School
Emotional or Sexual Abuse Other: _____

Chemical: Smoking Second Hand Smoke Medications Fumes
Junk Food "Recreational" Drugs Other: _____

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

1. What are the aspects of your life that very much please you, bring you joy or help you feel better about yourself? _____

2. Describe the particular factors or elements about your life, experiences, family, work, recreation, past injuries, genetics, dietary habits, exercises, outlook, etc. that you feel impair your opportunity for full expression of health: _____

3. Describe the particular factors or elements about your life, experiences, family, work, recreation, past injuries, genetics, dietary habits, exercises, outlook, etc. that you feel give you an edge or add to your health: _____

4. Is there anything else that may help to understand you, your history or your needs that has not been discussed on this survey? Yes No
Please explain: _____

Network Spinal Analysis is a lifestyle and a family affair.
It is our policy that all parents have their children examined.

Thank you for choosing this office for your health and well-being. I look forward to helping you in your healing process and assisting you in your journey to a greater quality of life.