



Center of the Universe Network Care

COMPREHENSIVE PROFILE

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: _____ How did you discover 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 Concerns or Symptoms and How They May Affect Your Life

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

2. Do you have any current health or spinal concerns and/or areas of your life you would like to see change? Yes No
If so, please describe: _____

3. When did this situation or concern begin? _____
4. Have you done anything about this situation or concern or gotten any advice or treatment for it? Yes No
If yes, what were you told? _____
5. What was done? _____
6. Did it seem to work? _____
7. What was different about **you** after treatment? _____
8. What was different about **your condition or symptom** after treatment? _____

9. What was different about **your concern about the condition or symptom** after treatment? _____

10. 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 a 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/play	0 1 2 3
Affect on social life	0 1 2 3	Affect on walking	0 1 2 3
Affect on exercise	0 1 2 3	Affect on eating	0 1 2 3
Concern about particular symptom/condition	0 1 2 3	Concern about Health	0 1 2 3

 Comments: _____
11. Have any other family members had the same or similar concerns? Yes No
 - a) What did he/she do about them? _____
 - b) Did it seem to work? _____
12. How aware of this are you during the day? 0 1 2 3 at night? 0 1 2 3
13. 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? _____
14. Is there any time of day or activity which makes you more aware of it? _____

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

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

17. If this condition or symptom were to go away tomorrow, what would be different about your life? _____

18. What are you doing in your life now that is different than if you did not have this condition/symptom? _____

19. Since this happened, have you changed any habits? _____
20. 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 is terrible, really bad, I am scared, and hope you can fix it for me.
 c) I feel stuck, and can't help myself right now.
 d) I deserve more than what I have been experiencing, and would like you to assist me in my healing.
 e) Anything else? _____
21. 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 |

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. 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? _____
4. 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? _____
 c) Where are these films now? _____
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. Has your spine ever been professionally adjusted? Yes No
- a) By whom and when? _____
- b) Why did you go? _____
- c) What did he/she do for you? _____
- d) Were you pleased? Yes No
- e) Are you still going? Yes No
- f) Does your family receive chiropractic care? Yes No
10. 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? _____
11. Have you had experience with the following health, treatment or healing modalities? Yes No
- If so, please describe when you went, for how long you went, and what the results were:
- Massage/Bodywork: _____
- Emotional Therapy/Psychotherapy: _____
- Osteopathy: _____
- Physiotherapy/ Occupational Therapy: _____
- Music/Dance/Sound/Light/Aromatherapy: _____
- Homeopathy/Herbalist: _____
- Ayurvedic: _____
- Oriental Medicine/Acupuncture: _____
- Nutritional Counseling/Therapy: _____
- Oxygen Therapy/Chelation Therapy: _____
- Rebirthing/breathwork: _____
- Yoga/Movement/Dance/Tai Chi/Chi Gong: _____
- Somato Respiratory Integration (SRI): _____
- Other: _____
12. Do you have an exercise, meditation, prayer, nutritional, or dietary program? Yes No
- If yes, please describe: _____
- _____
15. When stressed, how do you "center yourself" or "re-group"? _____
- _____

Part III: Stress Survey: Please grade the following stresses in order of increasing intensity on the following scale:

0 - no awareness of stress 1 - slight stress 2 - moderate stress 3 - extreme stress

1. Overall Physical Stress, Trauma: 0 1 2 3

Circle all applicable (past or present): falls, accidents, injuries, repeated postural stress impacts, difficult birth, traction, physical abuse. Other: _____

2. Overall Chemical Stress: 0 1 2 3

Circle all applicable (past or present): prescription drugs, over the counter drugs, recreational drugs, smoke, fumes, pollutants, food additives. Other: _____

3. Overall Emotional/Mental Stress: 0 1 2 3

Circle all applicable (past or present): loss of love one(s), rapid change in life situation, mental abuse, emotional abuse, sexual abuse, legal concerns, financial concerns, move of home, change in school, change in relationship with significant other, stress of being ill. Other: _____

4. Have you had a work and/or auto collision related injury? Yes No

If so, please describe: _____

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

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 questions 1 and 2:

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. For a slightly longer term goal, how do you hope to benefit from care in the office?

- _____ 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

3. Is there some aspect of your life that very much pleases you, brings you joy, or helps you feel better about yourself?

4. Are there any particular factors or elements about your life, experiences, family, work, recreation, past injuries, genetics, dietary programs, exercises, outlook, etc. that you feel impairs your opportunity for full glowing health? _____

5. Are there any particular factors or elements about your life, experiences, family, work, recreation, past injuries, genetics, dietary programs, exercises, outlook, etc. that you feel gives you an edge or adds to your wellness? _____

6. 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.

7. 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: _____

8. What would motivate you to tell others about the care you receive in this office, and encourage others to get in care?

Thank you for choosing Center of the Universe Network Care.

We are excited about assisting you as you continue on your journey towards greater wellness.