

# New Directions in Health

## COMPREHENSIVE HEALTH PROFILE

Last Name \_\_\_\_\_ First Name \_\_\_\_\_

Date Of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender M F Todays Date \_\_\_\_\_  
D M Y

Address: \_\_\_\_\_ City: \_\_\_\_\_ Prov \_\_\_\_\_

Postal Code \_\_\_\_\_ Home Tel. \_\_\_\_\_ Cell \_\_\_\_\_

E-Mail \_\_\_\_\_ Occupation \_\_\_\_\_

Who referred you and how did you discover our clinic? \_\_\_\_\_

Have you ever seen a Chiropractor before? YES NO / Date \_\_\_\_\_

Have you ever seen a Massage Therapist before? YES NO

Primary care physician:  
Name \_\_\_\_\_ Address \_\_\_\_\_ Phone . \_\_\_\_\_

---

**INSTRUCTIONS:** This questionnaire contains 5 sections. Unless you are specifically instructed to fill out certain sections we would like you to complete the whole questionnaire.

### SECTION 1: HEALTH/TRAUMA/MEDICAL/CHIROPRACTIC/HEALING HISTORY

What is your primary reason for your visit today? \_\_\_\_\_

Have you ever injured your body (neck, head, back, hips)? YES NO

If yes, please describe \_\_\_\_\_

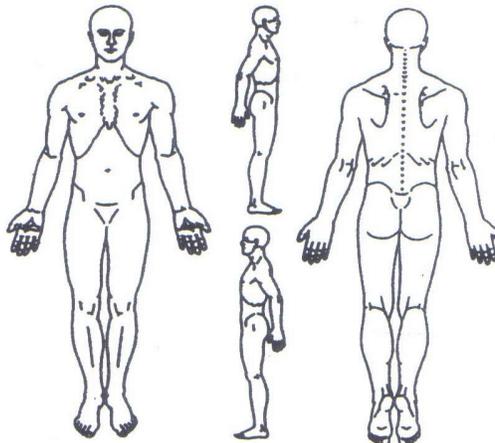
Have you had any spinal x-rays, CT scans or MRI imaging? YES NO. If yes, when?

What were you told? \_\_\_\_\_

Please list any major illnesses, hospitalizations, operations, or surgeries you have had and the year which they occurred? \_\_\_\_\_

Please list all medications, vitamins, herbs, supplements you are presently taking and the reasons for taking them? \_\_\_\_\_

**PLEASE USE THE DIAGRAM BELOW TO SHOW US WHERE AREAS OF PAIN OR UNUSUAL FEELING ARE:**



Please check the conditions that are applicable to you:

**Respiratory**

**Current**  
**Previous**  
 Chronic cough  
 Bronchitis  
 Shortness of breath  
 Asthma  
 Emphysema

**Skin**

**Current**  
 Skin condition;  
 type: \_\_\_\_\_  
 Bruise easily  
 Plantar warts  
 Rashes  
 Loss of sensation;  
 location: \_\_\_\_\_  
 Eczema/psoriasis;  
 location: \_\_\_\_\_

**Cardiovascular**

**Current**  
**Previous**  
 Heart attack; date: \_\_\_\_\_  
 Phlebitis  
 Stroke; date: \_\_\_\_\_  
 Pacemaker  
 High blood pressure  
 Low blood pressure  
 Chronic congestive heart  
 failure  
 Heart disease

**Infectious Conditions**

**Current**  
**Previous**  
 Tuberculosis  
 Hepatitis; type: \_\_\_\_\_  
 HIV

**Surgical Implants**

Pins Wires  
 Artificial joints or special equipment

**Digestive/Urinary**

**Current**  
**Previous**  
 Difficult digestion  
 Liver/gall bladder  
 Kidney/urinary bladder  
 Crohn's disease/colitis  
 Diabetes; onset: \_\_\_\_\_  
 type: \_\_\_\_\_  
 Ulcers

**Other Conditions**

**Current**  
**Previous**  
 Hemophilia  
 Epilepsy  
 Cancer; location: \_\_\_\_\_  
 Arthritis; ( ) RA ( ) OA  
 ( ) other; location: \_\_\_\_\_

**Muscles/Joints Pain or Discomfort**

**Current**  
**Previous**  
 Neck  
 Shoulders  
 Upper back  
 Middle back  
 Lower back  
 Hip  
 Knee  
 Ankle  
 Other: \_\_\_\_\_

Fibromyalgia  
 Chronic fatigue syndrome  
 Osteoporosis  
 Polio or post-polio syndrome  
 Scoliosis  
 Carpal Tunnel Syndrome  
 Herniated disc; location: \_\_\_\_\_  
 Muscle sprain/Ligament strain  
 Tendonitis/Bursitis  
 Fracture; location: \_\_\_\_\_  
 Whiplash; when? \_\_\_\_\_  
 Vision or hearing loss

**Female**

**Current**  
**Previous**  
 Gynaecological condition;  
 type: \_\_\_\_\_  
 Pregnant; due date: \_\_\_\_\_

Headaches  
 Dizziness  
 Ringing in the ears  
 Fainting  
 Other: \_\_\_\_\_

**SECTION 2:  
 YOUR HEALTH CONCERN/SYMPTOMS AND HOW THEY MAY AFFECT YOUR LIFE.**

Do you have a main health concern? If so, please describe: \_\_\_\_\_

When did it begin? \_\_\_\_\_

Have you seen anyone for your concern? YES No

If yes, who? and what were you told? \_\_\_\_\_

What was done? \_\_\_\_\_ Did it seem to work? \_\_\_\_\_

Have any other family members had the same or similar concerns? YES NO

**PLEASE GRADE THE LEVEL TO WHICH THIS HEALTH CONCERN(S) AFFECTS THE FOLLOWING ASPECTS OF YOUR LIFE**

	0	1	2	3		0	1	2	3
	<b>0 – It does not seem to affect me</b>								
	<b>1 – It seems to slightly affect me</b>								
	<b>2 – It seems to moderately affect me</b>								
	<b>3 – It seems to drastically affect me</b>								
affect on work	0	1	2	3	affect on family/relationships	0	1	2	3
affect on social life	0	1	2	3	affect on standing	0	1	2	3
affect on exercise/play	0	1	2	3	affect on walking	0	1	2	3
affect on love life	0	1	2	3	affect on sitting	0	1	2	3
affect on energy and vitality	0	1	2	3	affect on rest/sleep	0	1	2	3
my overall concern about my condition(s)/health	0	1	2	3					

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

**Do you think this is the sole cause? YES NO**

If no, what is involved \_\_\_\_\_

If this condition/symptom were to go away tomorrow, what would be different about your life

Are you doing anything differently because of this condition/symptom? Concern?

**SECTION 3: STRESS SURVEY**

**PLEASE GRADE THE FOLLOWING STRESSES ACCORDING TO THE KEY BELOW**

- 0 – No awareness of stress**
- 1 – Slightly stressful situation**
- 2 – Moderately stressful situation**
- 3 – Extremely stressful situation**

OVERALL PHYSICAL STRESS /TRAUMA: includes: falls, accidents, injuries, repeated postural stress, impacts, difficult birth, traction, physical abuse, etc.  
0 1 2 3

OVERALL EMOTIONAL/MENTAL STRESS: includes: loss of love ones, rapid change in life situation, mental, emotional, sexual abuse, legal concerns, financial concerns, move of home/school, separation/divorce etc. in relationship, stress of being ill. etc.  
0 1 2 3

OVERALL CHEMICAL STRESS: includes: drugs, smoke, fumes, food additives, poor nutrition, etc.  
0 1 2 3

CURRENTLY I WOULD GRADE MY OVERALL STRESS LEVEL TO BE:  
0 1 2 3

**SECTION 4: YOUR SPECIFIC NEEDS AND HOPES FOR HELP IN THIS OFFICE?**

**USE THE KEY BELOW FOR THE QUESTION THAT FOLLOWS:**

- 0 – Does not apply**
- 1 - Not so important to me**
- 2 – Important to me**
- 3 – Very important to me**

In a published study conducted at the University of California - Irvine's Medical School, patients under a specific Chiropractic approach called Network Spinal Analysis reported improvement in all of the categories of health and wellness listed below. How do you hope to benefit from Chiropractic care in this office?

- a) \_\_\_\_\_ Improvement in my physical symptoms
- b) \_\_\_\_\_ Improvement in my emotional/mental state
- c) \_\_\_\_\_ Improvement in my ability to handle stress
- d) \_\_\_\_\_ Improvement in my ability to make constructive choices for myself
- e) \_\_\_\_\_ Improvement in my vitality and enjoyment of life
- f) \_\_\_\_\_ Overall improvement in my quality of life

**When communicating to you about your body, health and wellness (circle your preference).**

- a) Mostly speak with me about the clinical findings. Tell me about the changes I am making.
- b) Mostly show me in written form the clinical findings. 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.

Is there anything else which may help us to understand you, your history, or your professional needs which have not been discussed in this survey?

---



---

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

---



---

**SECTION 5 INFORMED CONSENT**

**Email Database Consent**

I, \_\_\_\_\_ give permission to New Directions In Health to add my email address to its database in order to receive notices and events pertaining to the clinic and its practitioners. I understand that the database is used exclusively by New Directions In Health and it is not shared nor sold to any third parties, and I may withdraw my consent with notice at any time.

\_\_\_\_\_  
Signature Date

**Cancellation Policy**

I understand that New Directions In Health and its practitioners require 24-hour cancellation notice in order to avoid a charge to my account. New Directions In Health will charge me the full fee unless I give notice at least 24 hours in advance of any scheduled appointment.

\_\_\_\_\_  
Signature Date

