clinique chiropratique St-Joseph

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COMPREHENSIVE HEALTH PROFILE (4 pages)

Date (d/m/y) : ____/____/_____

Last name: _____ First name: _____
Date of birth (d/m/y) : _____ / _____ /_____ Gender : _____ Weight : _____ Height : _____
Status : _____ Children : _____ Occupation : _____
Address : _____ City : _____ Prov.: _____ Postal code : _____
Home phone : _____ Cell. phone: _____ E-mail address : _____
Who referred you to our office ? _____

Please complete this general 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 compromise to your wellness or health related quality of life that you may now be experiencing.

Part I - Your health concerns or symptoms and how they may affect your life.

1. What is the main purpose for your visit? _____
   Others reasons: _____
1a. Do you have any current health concerns? If so, please describe: _____
   _____
   _____
2. When did this situation or concern begin? _____
3. 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? _____
4. What was done? _____
5. Did it seem to work? _____
6. What was different about you after treatment? _____
7. What was different about your condition or symptom after treatment?
   _____
8. What was different about your concern about the condition or symptom after treatment?
   _____
9. Please grade the level to which these health concerns affect these aspects of your fonctioning/quality of life.

0 - It does not affect me 1 - It affects me slightly 2 - It affects me moderately 3 - It affects me extremely

Work	0 1 2 3	Recreation/play	0 1 2 3	Rest / Sleep	0 1 2 3
Social life	0 1 2 3	Walking	0 1 2 3	Sitting	0 1 2 3
Exercise	0 1 2 3	Eating	0 1 2 3	Love life	0 1 2 3
Concern about particular symptom/condition			0 1 2 3	Concern about health	0 1 2 3

Comments : _____

10. Has any other family member had the same or similar concerns? Yes _____ No _____
    What did he/she do about them? _____
11. 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 forget about this condition, symptom or concern about this? _____
14. Is there any time of day or activity which makes you aware of it?
    _____
15. Why do you think this has happened or continues to happen to you? _____
16. If this condition or symptom were to go away tomorrow, what would be different about your life?
    _____

17. What are you doing in your life now that is different than what you would be doing if you did not have this condition/symptom?_____
18. Since this happened:
    Have you changed any habits?_____
19. Which best describes your current feeling about yourself and your situation?
    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? _____
20. 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
    c) If your situation is not resolved, how much will it affect your life in the future? 0 1 2 3

Part II - Health/trauma/medical/chiropractic and healing history

1. Have you ever injured your spine (neck, head, back, hips)?
    a) Date of most significant injury (day/month/year) : ____ / ____ /____
    b) What happened? _____
    c) Date of the latest injury (d/m/y) : ____ / ____ /_____
    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 or head (neck, back or hips)?
    Yes _____ No _____ When? (d/m/y) : ____ / ____ /_____
5. What were you told about them? _____
6. Where are these films now? _____
7. Have you had any surgeries? Please explain: _____
    Which : _____
    Where : _____ Date : _____
8. Has your spine ever been professionally adjusted? Yes _____ No _____
    a) By whom and when? _____(d/m/y) : ____ / ____ /_____
    b) Why did you go? _____
    c) Are you still going? Yes _____ No _____
    d) What did he/she do for you? _____
    e) Were you pleased? Yes _____ No _____
    f) Does your family receive chiropractic care? Yes _____ No _____
9. Do you consult with a physician for other than routine evaluations? Yes _____ No _____
    What is/was the reason for the visit(s)? _____
    When was your last visit? : ____ / ____ /____What was done or suggested? _____
10. Do you have an exercise, meditation, prayer, nutritional or dietary program? Please describe :
    _____
11. When stressed, how do you 'center yourself' or 'regroup'? _____
    _____
12. Regular exercises (sports): _____
13. Date of last menstruations (d/m/y) : ____ / ____ /_____ Birth control (d/m/y) : ____ / ____ /_____

Part III - Stress survey

1. With each of the following stress situations, please check either ≪P≫ for Past and ≪C≫ for Current.

	MILD		*MODERATE*		*EXTREME*	
	P	C	P	C	P	C
Childhood stress	☐	☐	☐	☐	☐	☐
School stress	☐	☐	☐	☐	☐	☐
Play or recreational	☐	☐	☐	☐	☐	☐
Family Stress	☐	☐	☐	☐	☐	☐
Personal relationships	☐	☐	☐	☐	☐	☐
Stress of being sick	☐	☐	☐	☐	☐	☐
Work related stress	☐	☐	☐	☐	☐	☐
Stress of commuting	☐	☐	☐	☐	☐	☐
Loss of loved one	☐	☐	☐	☐	☐	☐
Change in lifestyle	☐	☐	☐	☐	☐	☐
Change in vocation	☐	☐	☐	☐	☐	☐
Abuse	☐	☐	☐	☐	☐	☐

2. Have you had a work/vehicular accident related injury? Yes _____ No _____
   Please describe : _____

Part IV - Your specific needs and hopes for help in this office?

In a published study of over 2,800 patients in Network Care, conducted within the Medical College at the University of California-Irvine, patients reported an overall improvement in all of the categories of health and wellness listed below.

1. Which of the following choices is currently of most interest to you? How do you hope to benefit from care in our clinic? Use this scale :
   a) Very important to me b) Important to me c) Not so important to me d) Does not apply

   a) _____ Improvement of my physical symptoms.
   b) _____ Improvement of emotional/mental symptoms.
   c) _____ Improvement of my ability to react or respond to stress.
   d) _____ Improvement in enjoyment of life and the ability to make conductive choices.
   e) _____ Overall improved quality of life.

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

3. 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, impair your opportunity for full glowing health?
   _____

Authorization Form

I hereby authorize the Chiropractor to carry out the examination that he deems necessary for the opening of my file. Some patients may experience stiffness or mild elevating symptoms after the exam. These symptoms are usually short lived, but it is important to mention them to the chiropractor at your next appointment.

Name of patient : _____ Date of birth (d/m/y) : ____ / ____ /_____

Signature of patient : _____

Have you had or do you have any of the following problems? (mark the appropriate case)

	Yes	No		Yes	No
Allergies			Operations / Surgery		
Anxiety			Kidney stones		
Arthritis			Shaking		
Abdominal gas			Foot problems		
Low blood pressure			Cardiac problems		
Constipation			Blood circulation problems		
Convulsions			Respiratory problems		
Itching			Eye problems		
Depression			Digestive problems		
Diabetes			Sexual problems		
Diarrhea			Hearing problems		
Easily bruised			Hormonal problems		
Numbness			Psychological problems		
Epilepsy			Kidney problems		
Skin eruptions (redness)			Varicose vein problems		
Dizziness/vertigo			Nose bleeds		
Loss of consciousness			Blood in the urine		
Cold extremities			Blood in the stools		
Fatigue			Sinusitis		
Fractures			Urinate frequently		
Shivers			Urinate at night		
High blood pressure			Prostate problems		
Hypoglycemia			Cancer		
Urinary incontinence			No menstruation		
Insomnia			Abdominal cramps		
Irritability			Abundant menstrual flow		
Hereditary diseases			Painful menstruation		
Back pain			Vaginal loss		
Headaches/Meningitis			Menopause symptoms		
Edema (swelling)			Are you pregnant?		

Family history

Father: age: _____
If deceased, cause:
_____

Mother: age: _____
If deceased, cause:
_____

Do you have brothers or sisters?
Yes ☐ No ☐

Do members of your family have:

Cardiac problems ☐
Cancer ☐ Diabetes ☐
Arthritis ☐ Other ☐ :
_____

What is your work position :

Standing ☐ Sitting ☐ Moving ☐
Do you wear:

A heel lift ☐ Shoe orthotics ☐

Do you usually sleep on your:

Back ☐ Side ☐ Stomach ☐

How many hours do you sleep at night?

4 and less ☐ 5-6 ☐ 7-8 ☐

9-10 ☐ 10-11 ☐ 12 and more ☐

Do you consume…? How many?

Tobacco/cigarettes Yes ☐ _____

Alcohol Yes ☐ _____

Coffee/tea Yes ☐ _____

Drug Yes ☐ _____

Do you take vitamins or supplements? Yes ☐ Which one:
_____

Do you exercise?

No ☐ Yes ☐

I hereby declare that the information in this questionnaire is correct and completed to the best of my knowledge.
Name of patient : _____ Date of birth (d/m/y) : ____ / ____ /_____

Signature of patient : _____