



## Confidential Health Profile

*Thank You for Printing Clearly*

Dear Practice Member:

Today's Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Please complete this questionnaire. Your answers will help us determine how best to serve you. THANK YOU.

Name \_\_\_\_\_  
LAST FIRST MIDDLE Age \_\_\_\_ Sex  M  F Date of Birth \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_ Zip Code \_\_\_\_\_  
Phone: Hm \_\_\_\_\_ Wk \_\_\_\_\_ Cell \_\_\_\_\_ E-mail \_\_\_\_\_  
Occupation \_\_\_\_\_ Marital Status S M W D Significant Other # of Children: \_\_\_\_\_  
Nearest Relative and Telephone \_\_\_\_\_  
Insurance: \_\_\_\_\_ Social Security # (for insurance): \_\_\_\_\_  
Who referred you to our office and Network Chiropractic Care? \_\_\_\_\_

### YOUR HEALTH CONCERN OR SYMPTOM

Do you currently have any health concerns?  Yes  No If yes, please describe \_\_\_\_\_

When did this situation or concern begin? \_\_\_\_\_ Have you experienced this concern in the past? \_\_\_\_\_

Have you done anything about this concern or gotten advice or treatment for it?  Yes  No If yes, when? \_\_\_\_\_

Who did you see? \_\_\_\_\_ What were you told? \_\_\_\_\_ What was done? \_\_\_\_\_

What was different about **YOU**, after this experience? \_\_\_\_\_

Is there any time, or activity you can be involved with; when you **almost totally forget about** this condition, symptom, or concern? \_\_\_\_\_

Is there any time of day or an activity, which makes you **more aware** of it? \_\_\_\_\_

Do you think this is the sole cause?  Yes  No If no, what else is involved? \_\_\_\_\_

If this condition or symptom were to go away tomorrow, what would be different about your life? \_\_\_\_\_

What are you **doing in your life now** that is different than if you did not have this condition/symptom? \_\_\_\_\_

Since this happened...have you changed any habits? \_\_\_\_\_

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 looking for assistance in becoming healthier so I can move past my health concern.
- I realize my condition may be a necessary experience in getting to the real problem.
- 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.

Please circle the level that this health concern(s) affects the following aspects of your daily 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/Play	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
Overall Concern about Symptom or Condition			0 1 2 3	Concern about Health	0 1 2 3

### CHIROPRACTIC HISTORY

Have you received chiropractic care in the past?  Yes  No If yes, Dr's Name: \_\_\_\_\_  
 How often did you receive adjustments? \_\_\_\_\_ For how long? \_\_\_\_\_ Date of your last adjustment? \_\_\_\_\_  
 If you stopped going, why? \_\_\_\_\_  
 Do you know what type of adjustments or what technique(s) or methods she/he used? \_\_\_\_\_  
 Were you pleased with her/his service?  Yes  No Why? \_\_\_\_\_  
 Does your immediate family receive chiropractic adjustments? \_\_\_\_\_

~~~~~  
 Have you had, or do you receive the following vehicles towards growth and development? If yes, please mark:  
 Acupuncture  Massage/Bodywork  Osteopathy/Cranial Work  Meditation   
 Psychotherapy  Exercise/Movement  SRI  Yoga/Tai Chi  Other \_\_\_\_\_

### GENERAL PHYSICAL HISTORY

Have you ever injured your spine (neck, head, back, hips)?  Yes  No  
 Date of most significant injury: \_\_\_\_\_ Describe: \_\_\_\_\_  
 Date of most recent injury: \_\_\_\_\_ Describe: \_\_\_\_\_  
 Have you ever been in an Auto Accident?  Past Yr  Past 5 Yrs  Over 5 Yrs  Never  
 Describe: \_\_\_\_\_  
 Have you had any other injuries (job, sports, etc.)?  Past Yr  Past 5 Yrs  Over 5 Yrs  Never  
 Describe: \_\_\_\_\_  
 Have you had spinal x-rays, CAT scans or MRI's of your spine (head, neck, back or hips)? If yes, when? \_\_\_\_\_  
 What were you told about them? \_\_\_\_\_ Where are these films now? \_\_\_\_\_  
 Have you had any surgeries? Describe: \_\_\_\_\_  
 Have you broken any bones or significantly sprained a part of your body? Describe: \_\_\_\_\_  
 Have you ever been hospitalized?  Past Yr  Past 5 Yrs  Over 5 Yrs  Never  
 Describe: \_\_\_\_\_  
 Are you aware if your birth was?  Traumatic  Breech  "C" Section  Prolonged  Cord around Neck  
 Other Comments: \_\_\_\_\_

Do you exercise regularly?  Yes  No If yes, what kind? \_\_\_\_\_

### MEDICATIONS, DIET, AND CHEMICAL EXPOSURES

Please list all medications you have taken in the past 60 days, and the reasons you have taken them, (prescription and non-prescription): \_\_\_\_\_

In the past, have you taken other medications for a period of more than 3 months?  Yes  No  
Please list medications and reason for taking them: \_\_\_\_\_

Do you or did you work with any chemicals, fumes, dust, powder, smoke, or any other toxic chemicals for prolonged periods?  Yes  No If yes, please explain: \_\_\_\_\_

Do you have any allergies? Describe: \_\_\_\_\_

Are you on a special diet?  Yes  No If yes, what kind? \_\_\_\_\_

How would you describe your general daily eating habits? \_\_\_\_\_

How often do you consume the following products?  Artificial Sweeteners (NutraSweet, Equal, Aspartame) Y N

Smoking: Amount/Day: \_\_\_\_\_  Coffee: Cups/Day: \_\_\_\_\_  Refined Sugar - Candy/Pastries/Day: \_\_\_\_\_

Alcohol: Drinks/Week: \_\_\_\_\_  Soda: # / Day: \_\_\_\_\_

### STRESS SURVEY

Please grade and circle your Past/Current Life Stresses using the following scale:

0 - No awareness of any stress    1 - Slightly stressful    2 - Moderately stressful    3 - Extremely stressful

**Overall Physical Stress/Trauma**    *Please check all that apply.*  falls,  accidents,  injuries,  impacts,  postural stress,  difficult birth,  physical abuse,  Other \_\_\_\_\_  
0 1 2 3

**Overall Emotional/ Mental Stress**    *Please check all that apply.*  loss of loved ones,  legal concerns,  work related stress,  financial concerns,  stress of being ill,  rapid change in life situation,  change in home/school/job,  relationship stress,  separation/divorce,  mental/emotional abuse,  Other \_\_\_\_\_  
0 1 2 3

**Overall Chemical Stress**    *Please check all that apply.*  drugs,  smoke,  fumes  alcohol,  caffeine,  allergies,  chemical exposure,  food additives,  anesthesia,  perfumes/colognes,  Other \_\_\_\_\_  
0 1 2 3

When stressed, how do you "center yourself" or "re-group"? \_\_\_\_\_

### YOUR SPECIFIC NEEDS AND HOPES FOR HELP IN THIS OFFICE

In a published study of over 2,800 patients in Network Spinal Analysis Care, conducted at the University of California, Irvine Medical College; patients reported an overall improvement in *all* of the categories of health and wellness listed below. How do you hope to benefit from care in this office?

- 0 - Does Not Apply    1 - Not So Important To Me    2 - Important To Me    3 - Very Important To Me
- \_\_\_ Improvement of my **Physical Symptoms**.
  - \_\_\_ Improvement of **Emotional/Mental Symptoms**.
  - \_\_\_ Improvement of my **Ability to React or Respond to Stress**.
  - \_\_\_ Improvement in **Enjoyment of Life** and the ability to make **Healthier, more Constructive Choices**
  - \_\_\_ Overall improvement in **Quality of Life**.

Is there anything else which may help us to better understand you, your history, or your needs that have not been addressed in this survey? Please explain: \_\_\_\_\_

What do you hope to receive from Network Care in this office? \_\_\_\_\_

How will you know your expectations have been met? \_\_\_\_\_

What would motivate you to tell others about the care you receive in this office, and to encourage others to be under Network Care? \_\_\_\_\_

**Thank you for choosing our Chiropractic Office. We are looking forward to helping you develop a healthy spine and nervous system. We are excited about assisting you on your journey to greater health and wellness.**

**Dr. Michele Pelletiere**

Chiropractor

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**ACTUAL CONDITION**

- 1- Briefly describe your symptoms : \_\_\_\_\_  
\_\_\_\_\_
- 2- How did this problem begin ?  Suddenly  Gradually
- 3- When did this begin ? \_\_\_\_\_ weeks \_\_\_\_\_ months \_\_\_\_\_ years
- 4- What caused this problem :  
 a violent effort  a fall  lifting an object  a motor vehicle accident  
 a work injury  pregnancy  sports  no apparent cause  
 other, specify \_\_\_\_\_
- 5- Is the pain :  constant  intermittent (comes and goes)
- 6- The pain is more intense (stronger) :  on waking  during the day  during the evening  at night
- 7- How do you describe your pain and discomfort :  
 burning  numbing  itching  loss of sensation  muscle stiffness  
 lancinating  bruise like  pinching  sharp  lack of energy
- 8- What aggravates your pain :  
 sitting  stress  sports \_\_\_\_\_  working leaning forward  
 lying down  eating  rising after sitting  vacuuming  
 coughing/sneezing  sitting in a car  prolonged periods in the same position  shovelling  
 urination  sitting for long periods  going up or down stairs  raking  
 during specific movements (specify) \_\_\_\_\_  
\_\_\_\_\_  
 other, specify \_\_\_\_\_
- 9- What relieves your pain :  
 lying down  walking  changing position  heat  ointment application  
 sitting  standing  exercising  cold  medications  
 other specify \_\_\_\_\_
- 10- Does your problem prevent you from :  working  sleeping  relaxing  doing hobby  
 carrying out daily activities  your relations with family and friends
- 11- Your problem appears to be :  getting worse  improving  remaining stable
- 12- Did you consult another health professional for this problem ?  yes  no  
if yes, who \_\_\_\_\_ when \_\_\_\_\_
- 13- Did you have X-rays taken during the last year ?  yes  no  
if yes, in what region(s) of your body \_\_\_\_\_

## NETWORK SPINAL ANALYSIS (NSA)

### Consent Form

I hereby request and consent to receiving spinal care, including wellness education in this office by a chiropractor(s) who provides Network Spinal Analysis (NSA) Care, a low force approach which has unique outcomes and clinical results. This practitioner(s) chooses to practice NSA, as he/she is professionally and personally confident in regard to the safety and effectiveness of this form of care.

This office provides care in accordance with the *Council on Chiropractic Practice Guidelines* and the *Canon of Ethics of the Association for Network Care*, and my doctor(s) has been trained in traditional chiropractic care and certified in the procedures of Network Spinal Analysis Care.

The purpose of this consent is to help me better understand the nature of the services offered in this office and our mutual responsibilities. This fosters a more effective relationship and avoids misunderstandings regarding expectations. Having well understood expectations is anticipated to promote a greater sense of safety and healing.

NSA consists of gentle touch contacts along the neck and back to achieve greater communication between the brain and body, and new sensory and motor strategies. NSA adopts an approach associated with somatic (body/spinal awareness) training. There is a body of research characterizing NSA care and documenting its unique and significant wellness benefits. I understand I may obtain copies of published research articles and/or abstracts in this office.

I am aware that I will receive gentle touch Network adjustments, also called entrainments. Assessments of my progress will include monitoring of my spine and body awareness, responsiveness to inner rhythms, tension and ease patterns. At regular intervals, following commencement of care, re-assessments will be performed. These will include my personal perception of my wellness and my awareness of my spine and body-mind changes. My chiropractor(s) will report to me the improvement in my spinal and nervous system integrity and my ability to self-regulate tension and to re-organize my spine.

I understand that this procedure is performed in an open room setting and *my adjustments may incidentally be observed and that conversations with the doctor may incidentally be overheard by other clients*. I understand that all initial consultations/examinations and progress evaluations are done in private and if at any time during care I wish to discuss my care privately, I may set up an appointment for a consultation with the doctor. In this office, client confidentiality and privacy is always honored and in compliance with all HIPAA privacy statutes.

I have read or have had read to me, the CONSENT TO RECEIVE NETWORK SPINAL ANALYSIS (NSA) CARE and understand that the care in this office is different from what many consumers may expect from chiropractors practicing manipulative therapy. *I agree to receive care, which consists of or includes NSA care and wellness education. I understand that I am not passive in this process, but that I am an active participant in my care and in my healing.*

PRINTED NAME OF PRACTICE MEMBER \_\_\_\_\_

SIGNATURE OF PRACTICE MEMBER \_\_\_\_\_

DATE \_\_\_\_\_