Last Name: First Name: Date:

Address: City: State:

Zip: Home Phone: Work Phone:

E-Mail: Date of Birth: Occupation:

How did you discover our office and the professional services we offer?

Please complete this general health history and wellness survey. It will provide your practitioner with important information to better understand your history and long term needs, as well as any wellness or health related quality of life compromise you may now be experiencing.

Part I : Your Health Concern or Symptoms and How They May Influence Your Life

1. Do you have a current health/life situation or concern? If so, please describe.

2. When did this situation or concern begin?_____
3. Have you done anything about this situation or concern, or been given 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. Have your concerns changed since treatment?.

9. Please grade the level to which this health concern(s) affects these aspects of your functioning/ quality of life.

   0 - It does not seem to affect me. **1 - It seems to slightly affect me.**

   2 - It seems to moderately affect me. **3 - It seems to drastically affect me.**

   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. Have any other family members 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 activity during which you totally, or almost totally, forget about this condition, symptom, or concern?_____
14. Is there any time of day which makes you more/less aware of the above?_____
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 ☐
17. If no, what else is involved?_____

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

19. Are you doing anything differently because of this condition/symptom/concern?

20. Since the development of this condition/symptom/concern:
    a) Have you changed any habits?_____
    b) Held or touched part of your body more often or differently? —
    c) Moaned, cried, or made sounds that you usually do not make?.
21. 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; 1 am scared and hope you can fix it for me. ☐....
    c) I feel stuck and can't help myself right now. ☐
    d) 1 deserve more than what I have been experiencing and would like you to assist me in my healing. ☐
    e) Anything else? _____
22. 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 three consecutive 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, CT scans, or MRI imaging of your spine, head, neck, back, or hips?
    Yes ☐ No ☐ If yes, when?_____
5. What were you told about them? _____'_____
6. Where are these films now? _____
7. Have you had any surgeries? Yes ☐ No ☐ Please explain:

8. Have you broken any bones, or significantly sprained any part of your body? ☐ Yes No ☐
    Please explain: _____
9. Please list any herbs, nutritional supplements, or natural remedies you take regularly:

10. Have you consulted a physician or any other health care provider in the past three months? ☐ Yes No ☐

11. Has your spine ever been professionally adjusted/manipulated/entrained? ☐ Yes No ☐
    a) By whom and when?_____
    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) Have you received Network Spinal Analysis™ Care? Yes ☐ No ☐
    g) Has your family received Network Spinal Analysis™ Care? Yes ☐ No ☐

12. Do you consult with a physician for any other reason than routine evaluations? Yes ☐ No ☐
13. What is/was the reason for the visit(s)? _____
14. When was your last visit?_____
15. What was done or suggested?_____
16. Have you had experience with the following health treatments or healing modalities? 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 Medicine _____
    Oriental Medicine/Acupuncture_____
    Nutritional Cousenling/Therapy_____
    Oxygen Therapy/Chelation Therapy_____
    Rebirthing/Breathwork_____
    Yoga/Movement Dance/Tai Chi/Chi Gong_____
    Somato Respiratory Integration™_____
    Other_____
17. Do you have an exercise, meditation, prayer, nutritional, or dietary program? ☐ Yes No ☐
    Please describe: _____
18. When stressed, how do you "center yourself or "regroup"?

Part III: Stress Survey

Please grade the following stresses in order of increasing intensity:

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

1) Overall Physical Stress, Trauma: Includes: falls, accidents, injuries, repeated postural stress
0 1 2 3 impacts, difficult birth, traction, physical abuse.

2) Overall Emotional/Mental Stress: Includes: loss of loved ones; rapid change in life situation;
0 1 2 3 mental, emotional, sexual abuse; legal concerns; financial concerns; move of home/school; separation/divorce etc. in relationship; stress of being ill; etc.

3) Overall Chemical Stress: Includes: drugs, smoke, fumes, food additives, etc.
0 1 2 3 Comments: _____

4) Have you had a work/vehicle 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. In question 1 and 2 rate the five choices using this scale.

a) Very important to me **b) Important to me**
c) Not so important to me **d) Does not apply**

1. How do you hope to benefit from care in the office?
   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 constructive choices
   e) ☐ Overall improved quality of life

2. For a slightly longer term goal, how do you hope to benefit from care in the office?
   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 constructive choices
   e) ☐ Overall improved quality of life ... . -

3. Is there some aspect of your life that very much pleases you, brings you joy, or helps you to 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 impair your opportunity for full glowing health?_____

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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 give you an edge or add to your health?
   _____

Your answers to the following questions will help us better assist you to participate in a program of care specifically focused on your spine, your nervous system, your health and wellness.

6. When communicating to you about your spine, nervous system, 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.
7. Is there anything else which may help us to better understand you, your history, or your professional needs, which have not been addressed on this survey? Please explain: ———————————————

8. What would motivate you to communicate to others about the care you receive in this office and to encourage others to seek care? _____

Thank you for choosing our Network Spinal Analysis™ office. We are looking forward to helping you to become successful in your ability to develop new strategies for a healthy spine, nervous system and life. We are excited about the possibility of assisting you as you continue on your journey towards greater health and wellness.