Dr. Jenna Eidt
CREATING BALANCE FOR YOUR LIFE

Comprehensive Health Profile

Name: _____ Address: _____

City: _____ Prov.: _____ Postal Code: _____ DOB: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Height: _____ Weight: _____ Marital Status: S M W D Name: _____ # of Children: _____

Occupation: _____ Email: _____

Who referred you to our office and the professional services we offer? _____

Have you had any Chiropractic Care in the past? □ Yes □ No **If yes**, were you pleased with their care? □Yes □No

PLEASE ANSWER THE FOLLOWING QUESTIONS ABOUT YOUR PERSONAL HISTORY

1) Do you have any health concerns/ symptoms? □Yes □No

PleaseDescribe: _____

_____

2) How do these health concerns interfere with the following areas of your life? :

WORK: _____

FAMILY: _____

HOBBIES: _____

LIFE: _____

3) Have you done anything or sought treatment for this situation or concern? □Yes □No

If yes, what were you told? _____

4) What was done? _____ Did it seem to work? _____

5) What was different about **YOU**, after the treatment? _____

6) What was different about your **CONDITION** or **SYMPTOM** after your treatment? _____

7) Why do you think this has happened (or continues) to happen to you? _____

Do you think this is the sole cause? □ Yes □ No

If No, what else is involved? _____

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

_____

***On a scale of 1 to 10, with 10 being the highest, rate your commitment in helping us solve this problem: _____**

9) 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'm 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 something to help me enhance my quality of life and further enhance my wellness

10) What do you hope to receive from care in this office? _____

-- PHYSICAL HISTORY --

Birth Stress: Information about your birth history:

1) Did your mother have a difficult pregnancy with you? □Yes □No

2) Was your birth traumatic? □Yes □ No

3) Was your birth: □ Drug induced □ Forceps or Suction □ Prolonged
□ C-Section □ Cord around neck □ Breech
□ Natural (No Drugs) □ Other: _____

GENERAL PHYSICAL TRAUMA:

4) Were you ever knocked unconscious? □ Yes □ No How/When? _____

5) Have you ever broken any bones? □ Yes □ No Which one? _____

6) Have you ever had any impacts and/or falls that you feel specifically may have injured your spine? □ Yes □ No
How/When? _____

7) Have you ever injured your head, neck, back or hips? □ Yes □ No How/When? _____

8) Have you served in the military? □ Yes □ No **If yes,** were you involved in combat? □ Yes □ No

9) On average, how many hours per day do you participate in the following? Sitting ____ Standing ____Desk Work ___Phone Work ____
Computer Work ____ Driving ____ Lifting Heavy Objects ____ Manual Labour ____ Stooping/Bending/Kneeling ____

SPORTS OR LEISURE:

10) Were you, or are you active in any sport(s)? □ Yes □ No Which One(s)? _____

11) Have you been hurt in any of these activities? □ Yes □ No Where? _____

AUTOMOBILE ACCIDENTS:

12) Have you, (even as a passenger, even if you do not think you were hurt), been involved in a car accident, or near collision?
Please list approximate dates and severity: _____
Bus, bicycle, motorcycle, train, airplane, moped, or other vehicles: _____

MEDICAL TREATMENT:

13) Have you ever been hospitalized? □ Yes □ No **If yes,** what was done to you? _____

14) Have you had surgery? □ Yes □ No **If yes,** what was done to you? _____

15) Have you ever had: □ Spinal Tap □ Spinal Injections □ Physiotherapy □ Neck Collar □ Spinal Brace □ Heel Lift
□ X-Ray Treatments □ Corrective Shoes or Bars □ Traction □ Extensive Diagnostic X-Rays □ Acupuncture □ Chemotherapy
□ Blood Transfusion □ Body Part in a Cast or Immobilized?

-- CHEMICAL HISTORY --

BIRTH STRESS:

1) Was your mother regularly taking any drug prior to, or during her pregnancy with you? □ Yes □ No

2) Did she use: □ Alcohol □ Cigarettes □ Other: _____

3) Was her labour chemically induced or altered? □ Yes □ No

4) Was your mother: □ Conscious □ Semi-Conscious □ Unconscious during delivery □ Under spinal anesthesia during delivery?

GENERAL CHEMICAL TRAUMA:

5) Are you taking any drug(s) (prescription or over-the-counter) regularly? Please list drug(s), when prescribed and reasons for taking them: _____
_____

6) Do you now, or in the past, have a history of alcohol/drug abuse or heavy use? □ Yes □ No
Please Describe: _____

7) Do you or did you work with any chemical, fume, dust, powder, smoke for prolonged periods? □Yes □ No
Please Describe: _____

8) Please indicate how much of the following products you consume:
Alcohol – Drinks/week: _____ Coffee – Cups/day: _____ Tobacco – Amount/day: _____
Artificial Sweeteners □Yes □ No Soda - #/day: _____ Refined Sugar – Candy/Pastries/day: _____

9) Do you use commercial household cleaners and personal care products (ie. Lysol, Tide, Dove, Mr. Clean, etc.)? □ Yes □ No
Have you experienced any symptoms related to their use? If YES, what? _____
Would you be interested in learning about healthier products to use for your home and body? □ Yes □ Not at this time

- EMOTIONAL HISTORY -

1) HOW DO YOU GRADE YOUR MENTAL/EMOTIONAL HEALTH?
Excellent *Good* *Fair* *Getting Better* *Getting Worse*

2) Have you experienced any emotional/mental traumas or situations in your childhood? If so, please describe: _____
_____

3) Have you experienced any recent emotional/mental traumas? If so, please describe: _____
_____

- OVERALL STRESS SURVEY -

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

0 - *No awareness* of any stress **1 - *Slight* stress** **2 - *Moderate* stress** **3 - *Extreme* stress**

A) Overall **Physical Stress/Trauma:** (includes: falls, accidents, injuries, repeated postural stress, impacts, difficult birth, physical abuse, loss of consciousness, broken/fractured bones, etc.)
0 1 2 3

B) Overall **Emotional/Mental Stress:** (includes: loss of loved ones, rapid change in life situations, abuse, move of home/school, legal concerns, financial concerns, divorce, relationships, etc.)

0 1 2 3

C) Overall **Chemical Stress:** (includes prescription drugs, over-the-counter medications, smoking, alcohol, caffeine, fumes, food additives, anesthesia, etc.)

0 1 2 3

YOUR SPECIFIC NEEDS AND HOPES FOR HELP IN THIS OFFICE?

A) ***Very Important to Me*** **B)** ***Important to Me*** **C)** ***Not so Important to Me*** **D)** ***Does Not Apply***

1) In published study of health and wellness benefits for patients under Network Care, conducted at the University of California, Irvine Medical College, patients reported an overall improvement in all of the following categories of health and wellness listed below (highlighted in **BOLD**). How do you hope to benefit from care in this office? (use scale from above to answer each category)

a) _____ Improvement of my **Physical Symptoms**
b) _____ Improvement of **Emotional/Mental Symptoms**
c) _____ Improvement in **Enjoyment of Life** and the ability to make **Healthier, more Constructive Choices**
d) _____ Improvement of my **Ability to React or Respond to Stress**
e) _____ Overall improvement in **Quality of Life**

2) Is there anything else you may wish to share which may help us better understand you, your history, or your professional and personal needs which have not been discussed in this profile? (if necessary, please use the back of this form)
_____
_____

3) What would motivate you to tell others about the care you receive in this office and encourage others to get under Care?
_____