Comprehensive Health Profile

Date: _____ / _____ / _____

Name: _____ Address: _____

City: _____ State: _____ Zip: _____ Occupation: _____

Home Phone: _____ Business Phone: _____

Cell Phone: _____(Used only if we need to change an appointment)

Date of Birth: _____ Age: _____ Height: _____ Weight: _____ Marital Status: S M W D

Number of Children: ____ Email:_____(used for educational purposes and important announcements)

Do you want to receive our monthly educational newsletter?___Yes ____ No (we do not share your email with anyone)

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

Have you received any type of chiropractic care in the past? ☐Yes ☐No Were you pleased with their care? ☐Yes ☐No

If yes, why did you discontinue your chiropractic care? _____

PLEASE ANSWER THE FOLLOWING QUESTIONS ABOUT YOUR PERSONAL HISTORY

1) Why are you here (Health Concern)? _____

_____

_____

2) Please grade and circle the level to which this health concern(s) affects the following 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.**

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
Concern about Particular Symptom/Condition	0 1 2 3	Concern about Health/Well-Being	0 1 2 3		

3) Have you done anything or sought treatment for this situation or concern? ☐Yes ☐No If yes, what were told? _____

_____

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

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

6) What was different about **YOU**, after 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) 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.

9) If this condition or symptom were to go away tomorrow, what activities would you be able to do again?_____

_____

10) What do you hope to receive from Network 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) Did your mother have any falls, accidents or physical injuries during pregnancy? ☐Yes ☐No
3) Was your birth traumatic? ☐Yes ☐No
4) Was your birth: ☐Drug induced ☐Forceps or Suction ☐Prolonged
   ☐"C" Section ☐Cord around the neck ☐Breech
   ☐Natural Fast Delivery ☐Other: _____
   Epidural Antibiotics
5) Describe any other physical or mechanical stress to your mother or you as labor progressed, delivery progressed, or as a newborn:_____

GENERAL PHYSICAL TRAUMA:

6) Were you ever knocked unconscious? ☐Yes ☐No How/When? _____
7) Have you ever broken any bones? ☐Yes ☐No Which Ones? _____
8) Have you ever had any impacts, falls, or jolts that you feel specifically may have injured your spine? ☐Yes ☐No
How / When? _____
9) Have you ever injured your head, neck, back or hips? ☐Yes ☐No How/When? _____
10) Have you served in the military? ☐Yes ☐No If yes, were you involved in combat? ☐Yes ☐No
11) 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 Labor __Stooping/Bending/Kneeling

SPORTS OR LEISURE:

12) Were you, or are you active in any sport(s)? ☐Yes ☐No Which One(s)? _____
13) Have you been hurt in any of these activities? ☐Yes ☐No Where? _____

AUTOMOBILE ACCIDENTS:

14) 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 (Mild, Moderate, Extreme).
Automobile: _____
Bus, bicycle, motorcycle, train, airplane, moped, or other vehicles: _____

MEDCIAL TREATMENT:

15) Have you ever been hospitalized? ☐Yes ☐No If yes, what was done to you? _____
16) Have you had surgery? ☐Yes ☐No If yes, what was done to you? _____
17) Do you have all of your body parts? ☐Yes ☐No If no, please describe: _____
18) Have you ever had: ☐Spinal Tap ☐Spinal Injections ☐Physiotherapy ☐Neck Collar ☐Spinal Brace ☐Traction
☐Heel Lift ☐X-Ray Treatments ☐Corrective Shoes or Bars ☐Extensive Diagnostic X-Rays
☐Acupuncture ☐Chemotherapy ☐Transfusion ☐Body Part in a Cast or Immobilized?
19) Are you/or have you ever been pregnant? ☐ No ☐Yes. How far along are you? _____

CHEMICAL HISTORY

BIRTH STRESS:

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

2) Did she use ☐Alcohol ☐Smoking ☐Other: _____

3) Was her labor chemically induced or altered? ☐Yes ☐No

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

5) Any other chemical stresses that your mother may have been subject to during pregnancy or labor? _____

_____

GENERAL CHEMICAL TRAUMA:

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

7) Were you previously taking any medication regularly? Which Ones / How Long?_____

_____

8) Do you now, or in the past have a history of alcohol / drug abuse or heavy use? ☐Yes ☐No

Please describe: _____

9) Do you or did you work with any chemical, fume, dust, powder, smoke for prolonged periods? ☐Yes ☐No

10) 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: _____

EMOTIONAL HISTORY

BIRTH STRESS:

1) My birth was: ☐At Home ☐In a Birthing Center ☐In a Hospital ☐Other

2) Were you incubated or isolated after birth? ☐Yes ☐No

3) Were you: ☐Bottle Fed Formula ☐Bottle Fed Mothers Milk ☐Nursed - How Long? _____ ☐Nursed and Bottle Fed?

GENERAL EMOTIONAL TRAUMA:

4) With each of the following potential spinal stress situations, please indicate the severity either past or current.

Potential Spinal Stress/Tension Sources	PAST	CURRENT
Childhood Stress	☐Mild ☐Moderate ☐Extreme	☐Mild ☐Moderate ☐Extreme
School Stress	☐Mild ☐Moderate ☐Extreme	☐Mild ☐Moderate ☐Extreme
Family Stress	☐Mild ☐Moderate ☐Extreme	☐Mild ☐Moderate ☐Extreme
Personal Relationships	☐Mild ☐Moderate ☐Extreme	☐Mild ☐Moderate ☐Extreme
Stress of Being Sick	☐Mild ☐Moderate ☐Extreme	☐Mild ☐Moderate ☐Extreme
Work Stress	☐Mild ☐Moderate ☐Extreme	☐Mild ☐Moderate ☐Extreme
Stress of Commuting	☐Mild ☐Moderate ☐Extreme	☐Mild ☐Moderate ☐Extreme
Loss of Loved One	☐Mild ☐Moderate ☐Extreme	☐Mild ☐Moderate ☐Extreme
Change in Lifestyle	☐Mild ☐Moderate ☐Extreme	☐Mild ☐Moderate ☐Extreme
Change in Vocation	☐Mild ☐Moderate ☐Extreme	☐Mild ☐Moderate ☐Extreme
Abuse (Verbal, Physical, Emotional, Sexual, etc)	☐Mild ☐Moderate ☐Extreme	☐Mild ☐Moderate ☐Extreme

Questionaire continues on the next page

OVERALL STRESS SURVEY

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

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

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, smoke, alcohol, caffeine, fumes, food additives, anesthesia from surgery, over-the-counter medications, etc.)
0 1 2 3

Please list any herbs, nutritional supplements, or natural remedies you take regularly:_____

_____

Do you have an exercise, meditation, prayer, nutritional or dietary program?_____

_____

When stressed, how do you "center yourself" or "regroup?_____

_____

YOUR SPECIFIC NEEDS AND HOPES FOR HELP IN THIS OFFICE?

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 below to answer each category)

A) *Very important to me* B) *Important to me* C) *Not so important to me* D) *Does not apply*

_____ 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.**

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

_____

_____

Chiropractic First

Dr. Elizabeth Erkenswick Welcomes You To Our Office

Prepared For: _____

Let me extend a warm and personal welcome to you on behalf of the staff and myself. We want to provide you with the finest health care and we'll offer you many informative and entertaining educational opportunities.

First, you'll want to make informed decisions regarding your health. During the course of your care you'll be presented with several choices that will affect your ability to reach your individual health objectives. Secondly, this information will be useful in making decisions about your health for the rest of your life. To begin this process, here are a few important terms and procedures as you begin care:

On your first visit we will gather information about you through our examinations and consultations. There will be someone here to assist you in each step along the way. If you're not sure about what we need, just ask. Nothing will be done without your consent and full understanding.

We will be giving you information and clinical data in the form of literature, personal and media presentations. these are designed to help you understand your own case and the procedures you'll experience in this office. Everything is brief and to the point. It is recommended that you read the material and keep it together for reference during the course of your care.

Just as we need to know about you, you should know about us. Chiropractic education currently consists of three years (90 hours) of pre-Chiropractic college education in the biological sciences, followed by another three years and four months (10 trimesters) of Chiropractic education and clinical internship. Then we are required to attend many hours of post-graduate education each year for license renewal. On top of this, our office is frequently involved in various seminars to keep abreast of the latest information.

We have minimized paper work in our office. However, there are clinical forms that must be filled out accurately for your health, legal and profession reasons. We ask that you read a form through before completing it so you understand its intent. If you have questions, please ask.

Your attitude about your health is as important to us as the specific reason you've consulted our office. Below is a space for your name and four descriptions of prevalent health attitudes. Please mark the one that most closely reflects your personal values.

Name: _____

☐ Treatment Only. I only consult a doctor when I have an ache or pain and discontinue care as soon as it has cleared up.

☐ Prevention. In addition to symptomatic treatment, I consult specialist occasionally to prevent problems from recurring.

☐ Maintaining Health. I'm conscious about my health, diet, exercise, etc. and actively pursue these because I feel better, perform better and it maximizes my potential.

☐ Family Health. I rake an active part in assisting, informing, and maintaining health, with my family. I'm concerned with the long-term affects of good health

Chiropractic First, S.C.
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Patients Advisory And Permissions - To Be Read And Signed By All Patients

We do not accept insurance plans. Rather, our assistance to you will be in the form of providing itemized receipts for your Chiropractic care which you may then submit to your insurance company. **Your insurance reimbursement will depend upon the nature of your policy.** By choosing care at Chiropractic First, you accept responsibility for payment of services as services are rendered.

If the patient is a minor, I as parent or guardian consent to have Dr. Liz Erkenswick render care to _____

I give authorization to disclose my records if required by my insurance provider or another healthcare provider.

I have read and understood the above information. I agree to pay as services are provided and I accept responsibility for pursuing insurance reimbursement.

SIGNED_____

DATE_____

Chiropractic First, S.C.

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 form 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 does not attempt to manually, or by instrument, manipulate spinal fixations structurally (often associated with a snapping or popping sound), nor does it directly treat painful areas of the spine and body. ***Instead, by enhancing my body's awareness of itself and specifically my spine, I understand I can develop new strategies for healing, adapting to stress, and experiencing wellness. These strategies promote spontaneous self-correction and self-regulation of spinal tension patterns 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 be receiving 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, reassessment 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 reorganize my spine.

NSA is advanced through a series of Levels of Care. Each Level of Care involves the development of new and unique spontaneous spinal wave motions, other body movements, and oscillations. These waves, which are suggested to be associated with greater spinal stability, the redistribution of energy, and the transfer of internal information are also associated with greater wellness, improved quality of life, and increased life enjoyment.

I also understand that, in addition to NSA care and wellness education, my practitioner(s) may perform additional examinations or assessments and offer health/.spinal care or advice that is consistent with my individual needs.

Network Spinal Analysis™ (NSA) Consent Form
contd.

Please Read and Sign the Following:

It has been explained to my satisfaction, and I understand that the care offered at this office is not a form of, or replacement for, the diagnosis or treatment of any symptom, disease, or malady. Instead, it is a form of wellness care and self-education that empowers my connection with my body-mind and develops new strategies for spinal and nervous system integrity and wellness. It develops new capacities in my body for the identification of, spontaneous release of, and redirection of tension, including those that are unique to NSA care.

It is common for people receiving NSA care to breathe more deeply and more fully, engaging the spine their respiration, to spontaneously adapt postures that release or redistribute tension, to bust stress, and to experience more of their inner life energy. I understand it is common to experience a wider range of motion and emotion during care. It is common, as care progresses, to find new options in the body and in life, which often lead to significant life changes.

This form of care is NOT suggested for those individuals who wish to remove a symptom or condition without the occurrence of other fundamental changes in their lives. The care in this office often promotes significant changes in health choices, lifestyle, experience of the body-mind, emotion, and consciousness.

Rather than attempting to simply return me to my previous state minus a symptom, this chiropractor instead chooses to help me achieve new levels of wellness and life potential that I may never have had before.

Although in this office we seek to help you develop new strategies for wellness and spinal and nerve system integrity, as a chiropractor the sole condition of concern is that of the vertebral subluxation. Our insurance carrier requires that the following information be given to you and signed by you prior to commencing care.

In Network Care, we categorize these subluxations into two categories, a structural segmental distortion and a spinal cord/nerve elongation or stretching. Through the gentle force applications at the spine to enhance spinal and nerve system integrity, subluxations are corrected. This is the only condition that we address in our office.

The only condition we offer to diagnose and correct is the vertebral subluxation and loss of spinal and neural integrity in relationship to this. We do not offer to diagnose or treat any other condition, disease, or symptom. If during the course of our spinal assessment/examination we encounter non-chiropractic or unusual findings, we will advise you of this. If you desire advice on further diagnosis or treatment of this condition, situation or circumstance, we will recommend that you seek the services of another health care provider whose practice is geared towards such differential diagnosis and treatment.

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 prac-***

_____
Printed Name of Practice Member

_____ _____
Signature of Practice Member DATE

_____
Printed Name of Witness

_____ _____
Signature of Witness DATE