HEALTH ASSESSMENT PROFILE

Name: _____

Birthdate: ___/___/___ Age: _____

Home Address: _____
(Street) (City) (State) (Zip code)

Email: _____

Home phone: ( ) _____ Marital status: _____

Office phone: ( ) _____ Names of children: _____

Cell number: ( ) _____ _____

Occupation: _____ _____

How did you discover our office and the amazing care we offer?

❑ friend/family ❑ co-worker ❑ internet ❑ talk/demo ❑ other

Thank you for your commitment in completing this 4 part profile; your care and recommendations depend upon it.

Part I: How Your Current Situation Is Affecting Your Quality Life

What health concern or situation prompted you to seek help here? _____

_____

And why NOW? _____

How long have you been aware of this concern? **___Days ___Weeks ___Months ___Years**

How much older do you feel because of this problem? (circle) **1-3 yrs 5yrs 10yrs 20yrs**

Have you gotten any advice about or treatment for this situation or concern? **Y / N**

What advice or treatment? _____

How long did your conern go away for? (circle) **Minutes Hours Days Weeks Months**

What do you feel is contributing to this? (ie. Diet, work, relationship, stress, activity, lifestyle, etc.)

Please describe: _____

_____

Is there any time of day or activity you can be involved with when you are not aware of your condition? **Y / N**

If YES, please briefly describe. _____

How is this condition affecting your life? ❑At Work / During week ❑During daily activities ❑Disrupts sleep
❑Can't enjoy my favorite activities ❑Affects family ❑Affects relationship(s) ❑Only on weekends
❑Other: _____

What do ***you*** think will happen to you if you continue down this same road?

❑ it will get worse ❑ it will ruin my life ❑ it will disrupt my family ❑ it will require surgery

On a scale of 1-10, with 10 being the highest, please rate your commitment in helping us address your problem: _____

Part II: Cumulative Stress Survey

Physical Stress

	Few		Several		Many			Few		Several		Many	
	Past	Present	Past	Present	Past	Present		Past	Present	Past	Present	Past	Present
falls/accidents	❑	❑	❑	❑	❑	❑	sitting / desk work	❑	❑	❑	❑	❑	❑
postural stress	❑	❑	❑	❑	❑	❑	frequent travelling	❑	❑	❑	❑	❑	❑
military service	❑	❑	❑	❑	❑	❑	repetitive tasks	❑	❑	❑	❑	❑	❑
sports impacts	❑	❑	❑	❑	❑	❑	extensive dental work	❑	❑	❑	❑	❑	❑
heavy lifting	❑	❑	❑	❑	❑	❑	other: _____						

Have you ever injured your spine (neck, head, back, hips)? **Y / N**
If YES, please explain when and what happened: _____

Have you had a work/vehicular accident related injury? **Y / N** Date: _____
❑Rear-ended ❑Head-on ❑"T" boned ❑Other: _____
Approx. speed: _____ mph
Briefly describe: _____

Medical Stress and Trauma

Do you still have all your body parts? **Y / N** If NO, please explain _____
I have had: ❑a spinal tap ❑spinal injections ❑physiotherapy ❑neck collar ❑spinal brace ❑traction ❑heel lift
❑radiation treatments ❑corrective shoes or bars in shoes ❑extensive X-rays ❑chemotherapy
❑body part in a cast or immobilized ❑hospitalization - what was actually done in the hospital? _____

Have you been diagnosed with any condition(s)? **Y / N**
If YES, what and how long ago? __Days __Weeks __Months __Years
Who diagnosed you? ❑ M.D. ❑ Family/Friend ❑ Self ❑ Internet Other: _____

If you are currently taking any medication(s), please list the medication(s) and the reason(s) for taking them.

_____

Please list any herb(s), nutritional supplement(s), or natural remedies you take regularly and the reason(s) for taking them.

_____

Do you consult with a physician for **other than** routine evaluations? **Y / N**
If YES, please explain: _____

Have you consulted with a physician or other health care provider in the past three months? **Y / N** Date: _____
If YES, please explain: _____
What was done or suggested? _____

Has any member of your family been diagnosed with any condition(s)? If YES, briefly complete below.

❑ Mother _____
❑ Father _____
❑ Brother _____
❑ Sister _____
❑ Other: _____

Part II: (Continued)

Chemical and Dietary Stress

Please check the appropriate boxes.

	DAILY		WEEKLY		MONTHLY		NOT AT ALL
	Past	Present	Past	Present	Past	Present	
drugs / medicines	❑	❑	❑	❑	❑	❑	❑
tobacco	❑	❑	❑	❑	❑	❑	❑
alcohol	❑	❑	❑	❑	❑	❑	❑
coffee / tea / soda	❑	❑	❑	❑	❑	❑	❑
sporadic eating	❑	❑	❑	❑	❑	❑	❑
diet food / artificial sweeteners	❑	❑	❑	❑	❑	❑	❑
dairy products	❑	❑	❑	❑	❑	❑	❑
meat products	❑	❑	❑	❑	❑	❑	❑
processed / fried foods	❑	❑	❑	❑	❑	❑	❑

Are you following a special diet? **Y / N** Please describe: _____

Mental / Emotional Stress

	Few		Several		Many			Few		Several		Many	
	Past	Present	Past	Present	Past	Present		Past	Present	Past	Present	Past	Present
loss of loved one	❑	❑	❑	❑	❑	❑	separation / divorce	❑	❑	❑	❑	❑	❑
change in lifestyle	❑	❑	❑	❑	❑	❑	commuting stress	❑	❑	❑	❑	❑	❑
abuse	❑	❑	❑	❑	❑	❑	feel pressured	❑	❑	❑	❑	❑	❑
significant move	❑	❑	❑	❑	❑	❑	work-related stress	❑	❑	❑	❑	❑	❑
relationship stress	❑	❑	❑	❑	❑	❑	family stress	❑	❑	❑	❑	❑	❑
feel overwhelmed	❑	❑	❑	❑	❑	❑	desire a life change	❑	❑	❑	❑	❑	❑

❑ other _____

Part III: Self-Care History

When you feel stressed, how do you "de-stress", unwind, or relax? _____

_____

Has your spine ever been professionally evaluated? **Y / N** ❑ chiropractor ❑ medical doctor ❑ osteopath (D.O.)

When? ❑ weeks ago ❑ months ago ❑ years ago

Why? _____

What did they do for you? _____

	Past	Present	Not at all	Comments:
Massage / Body work	❑	❑	❑	_____
Nutritional Counseling / Herbs	❑	❑	❑	_____
Osteopathy / Cranial work	❑	❑	❑	_____
Music- / Dance- / Sound-therapy	❑	❑	❑	_____
Homeopathy / Acupuncture	❑	❑	❑	_____
Rebirthing / Breathwork	❑	❑	❑	_____
Meditation / Prayer	❑	❑	❑	_____
Yoga / Tai Chi	❑	❑	❑	_____
Ayurvedic Medicine	❑	❑	❑	_____
Counseling / Psychotherapy	❑	❑	❑	_____

Other: _____

Part IV: Your Personal Needs

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

Rate the five choices ('a' - 'e' below) using the following scale:
(V) Very important to me (I) Important to me (NA) Not so important to me

How do YOU hope to benefit from care in our office?

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

What aspect of your life is a passion for you, pleases you, brings you joy or helps you feel better about yourself?

Are there any particular factors or elements about your life, your experiences, or your beliefs that you feel weigh you down or hold you back?

Best serving your needs, so that all of your desires for your care are met...!

Is there anything else which may help us to understand you, your history, or your professional needs?
Please explain:

Besides "getting results" or pain relief, what would you most like to experience in our office that would excite & inspire you?

We are excited about the possibility of assisting you as you continue on your journey towards greater health, happiness and well being! Thank you for the privilege of serving you!

Infinite Healing Arts Center
Consent For Purposes Of Care, Payment & Healthcare Operations

In this document, "I" and "my" refer to the patient, and "Practitioner" refers to Infinite Healing Arts Center.

I consent to the use or disclosure of my protected health information by Practitioner for the purpose of analyzing, diagnosing or providing care to me, obtaining payment for my health care bills or to conduct health care operations of Practitioner. I understand that analysis, diagnosis or care of me by Practitioner may be conditioned upon my consent as evidenced by my signature below.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out care, payment or healthcare operations of the practice. Practitioner is not required to agree to the restrictions that I may request. However, if Practitioner agrees to a restriction that I request, the restriction is binding on Practitioner. I have the right to revoke this consent, in writing, at any time, except to the extent that Practitioner has taken action in reliance on this Consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present and future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I have been provided with a copy of the Notice of Privacy Practices of Practitioner and understand that I have a right that Notice's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Practitioner. The Notice of Privacy Practices for Practitioner is also posted in the reception area of this office. This Notice of Privacy Practices also describes my rights and duties of the Practitioner with respect to my protected health information.

Practitioner reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office of Practitioner and requesting a revised copy be sent or asking for one at the time of my next appointment.

Terms Of Acceptance

When an individual seeks care in our office and we accept them as a patient or member of our practice, it is essential that we are both clear with respect to our goals and responsibilities. We understand that many people first come to our office seeking relief from some form of pain or discomfort. It is our first priority to make sure that each person knows whether we can be of service to help them or not.

We recognize that there is an innate ability of the body to be healthy, whole, and self-regulating and we understand that a body in a state of stress physiology may exhibit altered posture and/or spinal curves, muscle tension, and alterations in various functions of the nervous system.

We recognize vertebral subluxations as any spinal interference associated with stress physiology and an alteration of nerve function, resulting in a lessening of the body's innate ability to express its optimal health potential. We understand that care in our office helps the individual to eliminate such spinal interference and vertebral subluxations and to develop a healthier spine and greater nervous system integrity in each individual, regardless of the presence or absence of symptoms.

We do not offer to diagnose or treat any disease or symptom. We only offer to assess your loss of spinal and neural integrity in relationship to any spinal subluxations that may exist. If you have symptoms, a condition, or some disease about which you are concerned, we suggest you consult with another health care provider whose practice is geared towards such differential diagnosis and treatment. We may be able to assist you with an appropriate referral. Recommendations or suggestions regarding any medicines you are taking or wish to take remains the practice of medicine, which is outside our scope of practice. We feel that it is your responsibility to discuss this matter with your physician in relation to your current and long-term desires concerning your health and well being.

We are in agreement with the World Health Organization as they define health: a state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity. We choose to help each member of our practice achieve greater levels of spinal health, nerve system integrity, and overall quality of life and well being.

By my signature below, I acknowledge that I have read the above "Consent for Purposes of Care, Payment & Healthcare Operations" and the "Terms of Acceptance" and understand the contents of both. I choose to receive care for myself and/or my child for the above stated objectives of achieving greater levels of spinal health, nerve system integrity and wellness.

_____ _____

Signature of Patient or Personal Representative | Printed Name of Patient

_____ _____

Date of Signing | Description of Personal Representative's Authority