

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 professional services we offer? _____

This 4 part Health Assessment Profile provides important information to better understand your history, your present and longer term needs, and any compromise to your wellness or health related quality of life that you may now be experiencing. Your commitment to completing the questions will enhance your success in the care you receive.

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? Please explain. _____

When did this situation or concern begin? _____

Have you gotten any advice about this situation or concern or have you done anything or received any treatment? Y / N

If Yes, what were you told or what was done? _____

Did it seem to work? Y / N _____

What does treatment "working" mean for you? _____

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 totally or almost totally forget about this condition?

If YES, please briefly describe. _____

How is this condition affecting your life? At Work / During week During activity Disrupts sleep

Can't enjoy my favorite activities Affects family Affects relationship(s) Only on weekends

Other: _____

What is different about YOU now that you have this condition or symptom? _____

What are you doing in your life now that is different than if you did not have this condition or symptom? _____

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

Part II: Cumulative Stress Survey

Physical Stress

Please check the boxes that indicate how these physical stressors have been or are a part of your life:

	MILD		MODERATE		EXTREME			MILD		MODERATE		EXTREME	
	Past	Present	Past	Present	Past	Present		Past	Present	Past	Present	Past	Present
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
falls/accidents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	sitting / desk work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
postural stress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	frequent travelling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
military service	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	repetitive tasks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
sports impacts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	extensive dental work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
heavy lifting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	other: _____						

Have you had a work/vehicular accident related injury? Y / N

Date: _____

Rear-ended Head-on "T" boned Other: _____

Approx. speed: _____ mph

Briefly describe: _____

Have you ever injured your spine (neck, head, back, hips)? Y / N

If YES, please explain when and what happened: _____

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? _____

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 boxes that indicate how these chemical stressors have been or are a part of your life:

	DAILY		WEEKLY		MONTHLY		NOT AT ALL
	Past	Present	Past	Present	Past	Present	
drugs / medicines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
coffee / tea / soda	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
sporadic eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
diet food / artificial sweeteners	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
dairy products	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
meat products	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
processed / fried foods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you following a special diet?	Y / N		Please describe: _____				

Mental / Emotional Stress

Please indicate how these emotional and mental stressors have been or are a part of your life:

	MILD		MODERATE		EXTREME			MILD		MODERATE		EXTREME	
	Past	Present	Past	Present	Past	Present		Past	Present	Past	Present	Past	Present
loss of loved one	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	separation / divorce	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
change in lifestyle	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	commuting stress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	feel pressured	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
significant move	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	work-related stress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
relationship stress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	family stress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
feel overwhelmed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	desire a life change	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> 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

By whom and when? _____

Why did you go? _____

Are you still going? _____

What did he/she do for you? _____

	<u>Past</u>	<u>Present</u>	<u>Not at all</u>	Comments:
Massage / Body work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Nutritional Counseling / Herbs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Osteopathy / Cranial work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Music- / Dance- / Sound-therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Homeopathy / Acupuncture	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Rebirthing / Breathwork	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Meditation / Prayer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Yoga / Tai Chi	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ayurvedic Medicine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Counseling / Psychotherapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
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 (N) Not so important to me (NA) Does not apply

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, very much pleases you, brings you joy, or helps you to 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 "results", what specifically would you most like to experience in our office that would excite & inspire you? _____

We are looking forward to helping you to be successful in your ability to develop more ease in your body and in your life. 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 (3/03)

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, examination 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 care, 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 in the mail or asking for one at the time of my next appointment.

Terms Of Acceptance

When an individual seeks Network Spinal Analysis (NSA) care in our office and we accept them as a 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 know 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 recognize that NSA Care entrainments assist the body in moving beyond the state of stress physiology into new and effective strategies for healing and well being. We understand that NSA Care helps 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 through NSA Care.

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 NSA 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