Comprehensive Health Profile

Last Name: __________________ **First Name:** _________________ **Date:** _______________

Address: _________________________ **City:** ____________ **State:** _______ **Zip:** _________

Home phone: __________________ **Work:** _______________ **Mobile:** __________________

E-mail: _________________________________ **Date of Birth:** ________________________

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

____

Please complete this general health history survey, as it will provide your doctor with 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.

Part I: Your Health Concerns or Symptoms and How They May Affect Your Life

1. Do you have any current health concerns? If so please describe:
   ____
   ____
2. When did this situation or concern begin?
   ____
3. Have you done anything about this situation or concern or gotten 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. What was different about your concern about the condition or symptom after 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**

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	0 1 2 3

Comments:

____
____
____

10. Have any other family members had the same or similar concerns? **Yes No**
What did she/he 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 time, or activity you can be involved with when you totally or almost totally forget about this condition, symptom or concern?
____
14. Is there any time of day or activity, which makes you more aware of it?
____
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. What are you doing in your life now that is different than if you did not have this condition/symptom? ____
20. Since this happened: a) Have you change habits? ______________________
b) Held, or touched part of your body more 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, I am scared, and hope you can fix it for me.
c) I feel stuck, and can't help myself right now.
d) I 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
Currently, how inconvenient is your situation, condition or symptom? 0 1 2 3
a) 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)?
   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 3 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, Cat scans or MRI imaging of your spine or head (neck, back or hips)?______________________
   When? ______________________

5. What were you told about them? ______________________
6. Where are these films now? ______________________

7. Have you had any surgeries? Please explain: ______________________________

8. Have you broken any bones, or significantly sprained part of you 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?______________________________

11. Has your spine ever been professionally adjusted? **Yes** **No**
    a) By whom and when? ______________________________
    b) Why did you go? ______________________________
    c) Are you still going? ______________________________
    d) What did he/she do for you? ______________________________
    e) Were you pleased? ______________________________
    f) Does your family receive chiropractic care? ______________________________

12. Do you consult with a physician for other than routine evaluations? **Yes** **No**

13. What is/was the reason for visit(s)? ______________________________
14. When was your last visit? ______________________________
15. What was done or suggested? ______________________________
16. Have you had experience with the following health, treatment 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: ______________________________
    Psychotherapy/Occupational Therapy: ______________________________
    Music/Dance/Sound/Light/Aromatherapy: ______________________________
    Homeopathy/Herbalist: ______________________________
    Ayurvedic Medicine: ______________________________
    Oriental Medicine/Acupuncture: ______________________________
    Nutritional Counseling/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?
    Please describe: ______________________________
18. When stressed, how do you “center yourself” or “re group”?
    ____

Part III Stress Survey: Please grade the following stresses in order of increasing intensity.

0- means no awareness of any stress **1- slightly stressful situation**
2- moderately stressful situation **3- extremely stressful situation**

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

2) Overall Emotional/Mental Stress: 0 1 2 3 — Includes: Loss of love ones, rapid change in life situation, 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: 0 1 2 3 — Includes: drugs, smoke, fumes, food additives, etc.
Comments:

4) Have had a work/ vehicular accident related injury? **Yes No**
Please describe: ____

Part IV: Your Specific Needs and Hopes For Help in This Office?

Use this scale for questions 1 and 2
a) very important to me **b) important to me**
c) not so important to me **d) does not apply**

1. Which of the following five choices is currently of most interest to you. 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. How do you hope to benefit from care in the office?
   a)____ Improvement of 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 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 please 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?
   ____
   ____

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 adds to your health?
   ____

Your answers to the following questions will help us to help you to better participate in a program of care specifically focused on your spine, your nervous system, and 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 and tell me about the changes I am making
   b) Mostly show me in written form the clinical findings, and 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 understand you, your history, or your professional needs, which have not been discussed in this survey? Please explain:
   ____
   ____

8. What would motivate you to tell others about the care you receive in this office, and encourage others to get in care?
   ____
   ____

Thank you for choosing Sea Change New York. We are looking forward to helping you to be successful in your ability to develop a healthy spine and nervous system. We are excited about the possibility of assisting you as you continue on your journey towards greater health and wellness.

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.* 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, re-assessments 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 re-organize 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 the greater spinal stability, the re-distribution 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.

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 with 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 practitioner instead chooses to help me achieve new levels of wellness and life potential that I may never have had before.

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 practicing manipulative therapy. I agree to receive care, which consists of or includes NSA care and wellness education. I understand that I am not passive in this process, but that I am an active participant in my care and in my healing.***

______________________________	______________________________
Printed Name of Practice Member	***Date***
______________________________	______________________________
Signature of Practice Member	***Witness***