

Date _____ AHC# _____

Name: _____

Address: _____

City _____ Prov. _____ Postal code _____

Home# _____ Work# _____

Cell# _____ E-mail _____

Occupation _____



Birthday _____ Age _____ Marital status S M W D
(mm/dd/yy)

Spouse's name _____ Children Y N

Spouse's Occupation _____

Who may we thank for referring you to our office?

Part I:

Do you have a current health concern? If so please describe _____

When did this concern begin? _____ Have you done anything about this concern? Yes No

If yes, what were you told? _____

What was done? _____ Did it seem to work? Yes No

Please grade the level to which this health concerns effect these aspects of your quality of life.

- 0- It does not seem to effect me
- 1- It seems to slightly effect me
- 2- It seems to moderately effect me
- 3- It seems to drastically effect me

Effect on work 0 1 2 3 Effect on recreation/ play 0 1 2 3

Effect on social life 0 1 2 3 Effect of walking 0 1 2 3

Effect on exercise 0 1 2 3 Effect on eating 0 1 2 3

Effect on rest/ sleep 0 1 2 3 Effect on love life 0 1 2 3

Effect on sitting 0 1 2 3 Concern about health 0 1 2 3

Have any other family members had the same or similar concerns? Yes No

What did he/ she do about them? _____

How aware of this are you during the day? 0 1 2 3 At Night? 0 1 2 3

Is there any activity during which you totally, forgot about this condition, symptom or concern? _____

Is there any time of day which makes you more aware of the above? _____

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? _____

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

Are you doing anything different because of this condition/ symptom/ concern? _____

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 would like you to assist me in my healing

PART II:

Have you ever injured your spine (neck, head, back, hips)? _____

a) Date of most significant? _____ b) What happened? _____

Have you had any spinal X-rays, CT scans or MRI imaging of your spine or head? Yes No

When? _____ What were you told about them? _____

Where are these film now? _____ Have you had any surgeries? Please explain: _____

Have you broken any bones or significantly sprained part of your body? Yes No

Please explain: _____

Please list medication (prescription or non prescription) you have taken within the past 60

days: _____

In the past, have you taken other medication for a period of more the 3 months? Yes No

a) What did you take? _____

b) What was the reason for taking this medication? _____

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

Has your spine ever been professionally adjusted? Yes No

a) By whom and when? _____ b) Why did you go? _____

c) Are you still going? Yes No d) What did he/ she do for you? _____

e) Were you pleased? Yes No f) Has your family received Network Care? Yes No

Have you consulted a physician, or any other health care provider in the past 3 months? Yes No

Do you consult with a physician for other routine evaluations? _____

What is/ was the reason for the visits? _____

When was your last visit? _____ What was done or suggested? _____

Do you have an exercise, meditation, prayer, and nutritional or dietary program? Please describe: _____

When stressed, how do you do to re-group? _____

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

0-means no awareness of stress

1- slightly stressful situation

2- moderately stressful situation

3-extremely stressful situation

Overall Physical Stress and Trauma : Includes: falls, accidents, injuries, repeated postural stress impacts, difficult birth, traction, physical abuse:

0 1 2 3

Overall Emotional/ Mental stress: Includes: loss of love one, rapid change in life situation, mental, emotional, sexual abuse, legal concern, move of home/ school, separation, divorce, in relationship, stress of being ill:

0 1 2 3

Overall chemical stress: included: drugs, smoke, fumes, food additives:

0 1 2 3

Part IV: Specific Needs And Hope for Help in this Office?

Please uses this scale for the following questions:

1) Very important to me

2) Important to me

3) not so important to me

4) Does not apply

Which of the following five choices is currently of most interest to you.

How do you hope to benefit from care in the office?

a) ___ Improvement of my physical symptoms

b) ___ Improvement in emotional/ mental symptoms

c) ___ Improvement of my ability to react or respond to stress

d) ___ Improvement in enjoying of life and the ability to make constructive choices

e) ___ Overall improved quality of life.

Is there some aspect of your life that 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 that *you feel impairs* your opportunity for full glowing health?

Are there any particular factors or elements about your life that *you feel gives you an edge, or adds* to your health?

Your answer to the following questions will help you to better participate in a program of care specifically focused on your spine your nervous system and your health and wellness.

When communicating to you about your spine, nervous system, health and wellness: (circle your preference)

a) Mostly speak with me about the clinical findings. Tell me about the changes I am making.

b) Mostly show me in written form the clinical finding. 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.

Thank you for choosing our Network Spinal Analysis Office. 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.