Comprehensive Health Profile

Last Name: Joplin First Name: Jessica Date: 08/25/202

Address: 110 Jacob Fontaine Lane #147 City: Austin State: TX

Zip: 78752 Home Phone: _____ Cell Phone: 5128204852

E-mail: jessjoplin44@gmail.com Date of Birth: 10/29/1996 Occupation: PEA

How did you discover our office and the services we offer?
Shannon Law - referral :)

Please complete this general health history and wellness survey. It will provide your practitioner with important information to better understand your history and long term needs, as well as any wellness or health related quality of life compromise you may now be experiencing.

Part 1: Your Health Concern or Symptoms and How They May Influence Your Life

1. Do you have a current health/life situation or concern? If so, please describe:
   Major insomnia and anxiety.
2. When did this Situation or concern begin? ~10 years ago
3. Have you done anything about this situation or concern or been given any advice or treatment for it? ☑ Yes ☐ No
   If yes, what were you told? Tried medications, OTC, meditations, apps..
4. What was done? One medication helped slightly
5. Did it seem to work? Yes
6. What was different about after your treatment? Tired a lot
7. What was different about your condition or symptom after treatment? Tired a lot
8. Have your concerns changed since treatment? No
9. Please grade the level to which this health concern(s) affect 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.**

Work	0	Recreation/ Play	0	Rest/Sleep	3		
Social Life	0	Walking	0	Sitting	1		
Exercise	0	Eating	0	Love life	1		
Concern about particular symptom/condition	1	Concern about Health	1				

10. Have any other family members had the same or similar concerns? ☑ Yes ☐ No

    What did he/she do about them? Dad-insomnia. takes meds

11. Did it seem to work? Yes

12. How aware of this are you during the day? 1 at night? 3

13. Is there any activity during which you totally, or almost totally, forget about this condition, symptom, or concern? No

14. Is there any time of day that makes you more/less aware of the above? Night - more awar

15. If this condition or symptom were to go away tomorrow, what would be different about your life? Sleep pattern. anxiety.

16. Are you doing anything differently because of this condition/symptom/concern? No

17. Since the development of this condition/symptom/concern:

    Have you changed any habits? Try to put phone away, breathing techniques for ar

18. 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? D

Part II: Health/Trauma/Medical/Chiropractic and Healing History

1. Have you ever injured your spine (neck, head, back, hips)? ☐ Yes ☑ No

    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: Birth Control, Mirtazapine, xanax

3. In the past, have you taken other medications for a period of more than three consecutive months? ☑ Yes ☐ No

4. What did you take and for why? Anxiety

5. Have you had any spinal X-rays, CT scans, or MRI imaging of your spine, head, neck, back, or hips? ☐ Yes ☑ No If yes, when? _____

6. What were you told about them? _____

7. Where are these films now? _____

8. Have you had any surgeries? ☑ Yes ☐ No Please explain: Stomach surgery
_____

9. Have you broken any bones or significantly sprained any part of part of your body?
☐ Yes ☑ No Please explain: _____

10. Please list any herbs, nutritional supplements, or natural remedies you take regularly:
Probiotics

11. Have you consulted a physician or any other health care provider in the past three months?
☐ Yes ☑ No

12. Has your spine ever been professionally adjusted/manipulated/entrained? ☐ 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) Have you received Network Spinal Analysis ™ Care? ☐ Yes ☑ No

    g) Has your family received Network Spinal Analysis ™ Care? ☐ Yes ☑ No

13. Do you consult with a physician for any other reason than routine evaluations?
☐ Yes ☑ No

14. What is/was the reason for the visit(s)? _____

15. When was your last visit? N/A

16. What was done or suggested? _____

17. Have you had experience with the following health treatments or healing modalities? If so, please describe when you went, for how long you went, and what the results were:

    Massage/Bodywork Occasionally for relaxtion.

    Emotional Therapy/Psychotherapy _____

    Osteopathy _____

    Physiotherapy/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 Yoga for exercise.

Somato Respiratory Integration™ Care _____

Other:

_____

18. Do you have an exercise, mediation, prayer, nutritional, or dietary program? ☑ Yes ☐ No

19. When stressed, how do you "center yourself" or "regroup"?
Both?

Part III: Stress Survey

Please grade the following stresses in order of increasing intensity:

0- No awareness of stress **1- Slightly stressful situation**

2- Moderately stressful situation **3- Extremely stressful situation**

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

2) Overall Emotional/Mental Trauma:
1 ▼
Includes: loss of loved 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:
1 ▼
Includes: drugs, fumes, food additives,

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

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. In question 1 and 2 rate the five choices using this scale:

a) **Very important to me b) Important to me**

c) Not so important to me d) Does not apply

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

a) a Improvement of my physical symptoms

b) a Improvement of emotional/mental symptoms

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

d) a Improvement in enjoyment of life and the ability to make constructive choices

e) a Overall improved quality of life

2. For a slightly longer term goal, how do you hope to benefit from care in the office?

a) a Improvement of my physical symptoms

b) a Improvement of emotional/mental symptoms

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

d) a Improvement in enjoyment of life and the ability to make constructive choices

e) a Overall improved quality of life

3. Is there some aspect of your life that very much pleases you, brings you joy, or helps you to feel better about yourself? My boyfriend, my family, my dogs, exercixing and cooking!

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?
Past relationships,f insomnia and anxiety, IBS, family relationships - sister.

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 add to your health? Insomnia, anxiety, IBS.

Thank you for choosing our Network Spinal Analysis ™ office. We are looking forward to helping you to become successful in your ability to develop new strategies for a healthy spine, nervous system, and life. We are excited about the possibility of assisting you as you continue on your journey towards greater health and wellness.