# Pelletiere Confidential Health Profile

*Thank you For* ***Printing Clearly*** *. Your answers will help us to determine how best to serve you.*

*And thank you for choosing our Chiropractic office. We are looking forward to helping you develop a healthy spine and nervous system.*

*We are excited about assisting you on your journey to greater health and wellness -* ***Dr. Michele Pelletiere***

*Please fill out both sides of pages…*

**Date:** _____

**Last Name:**_____ **First Name:**_____ **MI:**_____

**Age:** _____ Date of Birth: ____/_____/_____ Sex: F M Marital Status: S M W D Significant Other

# of Children:_____

**Occupation:** _____ Phone #: _____ Email: _____

**Street Address:**_____**City:**_____**State:**_____ **Zip:** _____

**Nearest Relative:** _____ Phone #: _____

**Who referred you to our office for care?**_____

## Your Current Health Concern and/or Symptoms

Do you currently have any health concerns? **Y N** Have you experienced concerns in the past? **Y N**

Briefly describe your current symtoms:_____

_____

How did this problem begin? Suddenly _____Gradually _____

When did this begin? _____ Weeks _____ Months _____ Years

What caused this problem? _____

Violent effort: ____ a Fall: _____ Lifting :____ Auto: ____ Work injury: ____ Pregnancy: _____ Sports: _____ Unknown: _____

Other (Specify): _____

Have you done anything about this concern or received advice and/or treatment? **Y N** If **Yes**, When? _____

Who did you see? _____What were you told? _____What was done? _____

What was different about **YOU** after this experience? _____

Is there any time of day or activity which makes you **more aware** of it? _____

Is there any time of day or activity, when you **almost totally forget about it**? _____

Do you think the time of day and/or activity is the sole cause of the symptom? **Y N**

If No, what else is involved? _____

What would be different about your life, without the symptom? _____

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

_____

Since this happened…have you changed any habits?_____

How do you feel about your current condition? (Please check box in the ONE statement that BEST describes you feel)

| | |
|---|---|
| I feel helpless, nothing works. | |
| I don't like what I am feeling and hope you can fix it. | |
| I feel this is a pattern that has happened to me before; it's back again. | |
| I feel there is a message my body is giving me. | |
| I am looking for assistance in becoming healthier so I can move past my health concern | |
| I realize my condition may be a necessary experience in getting to the real problem. | |
| I don't know how I feel. I am too preoccupied with my present condition. | |
| I am looking for something to help me enhance my quality of life and further enhance wellness. | |

***Please*** circle the number that best describes your level of concern how this condition/symptom effects your daily functioning and/or quality of life.

0 = it does **NOT** effect me 1=**Slightly** affects me 2=**Moderately** affects me 3=**Drastically** affects me

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Work | 0 1 2 3 | Exercise | 0 1 2 3 | Walking | 0 1 2 3 | Rest/Sleep | 0 1 2 3 | Recreation/Play | 0 1 2 3 |
| Social Life | 0 1 2 3 | Love Life | 0 1 2 3 | Eating | 0 1 2 3 | Sitting | 0 1 2 3 | Concern of Health | 0 1 2 3 |

**Is the pain constant? _____ Intermittent (comes and goes)_____**

**Is the pain more intense (stronger) on:** walking: _____Daytime: _____Evening: _____Night: _____

**Describe your pain and/or discomfort:** Aching: __ Acute: ___ Annoying: ___ Burning: ___ Cramping: ___ Dull: ___ Electricical: ___

Nauseating: ___ Radiating: ___ Severe: ___ Sharp: ___ Stabbing: ___ Throbbing: ___ Touch Sensitive: ___ Unbearable: ___

**What aggravates your pain:** shoveling: _____ stress: _____ urination: _____ working/leaning forward: _____eating: _____

lying down: _____ raking: _____ vacuuming: _____ cough/sneezing: _____ up or down stairs: _____ Specify Other: _____

**What relieves your pain?** Lying down: _____walking: _____ changing position: _____ sitting: _____ standing: _____

heat: _____ cold: _____ exercising: _____ medications: _____ ointments: _____ Specify other: _____

**Does this prevent you from:** working: _____ sleeping: _____ relaxing: _____ hobbies: _____ daily/social activities: _____

**Does this appear to be:** getting worse: _____ improving: _____ remaining stable: _____

**Did you consult another health professional for this? Y N**

If yes, who:_____ when:_____

Did you have X-rays taken during the last year? **Y N**

if yes, what regions of your body:_____

# Chiropractic History

Have you received chiropractic care in the past? **Y N** If Yes Dr. Name:_____

How often did you receive adjustments? _____ For how long? _____ Date of last Adjustment? _____

If you stopped going…Why?_____

Do you know what type method and/or technique she/he used?_____

Were you please with her/his services? **Y N** If No, why not?_____

Does your immediate Family receive chiropractic care? **Y N**

# Medication, Diet and Chemical Exposures

Please list all medications you have taken in the **past 60 days**, and the **reason** you took them:_____

_____

In the past, have you taken any other medication for a period of more than 3 months? **Y N**

Please also list these past medications and the reason for taking them:_____

_____

_____

Do you or did you work with any chemicals, fumes, dust, powder, smoke or any other toxic chemicals for a prolonged time? **Y N**

Do you have any allergies? Y N Describe:_____

Are you on a special diet? Y N Describe:_____

Describe your general eating habits:_____

**If yes, how often do you consume the following products?** Coffee cups a day?_____ Alcohol drinks a day:_____

refined sugar/candy/pastry a day?_____ Artificial sweeteners NutraSweet/equal/aspartame a day:____ soda drinks:_____

# Stress Survey - Please grade your past/current life stressors by writing in the number from the scale below.

**0 = No awareness of stress** **1=Slightly stressful** **2=Moderately stressful** **3=Extremely stressful**

## Overall Physical Stress/Trauma

falls: _____ accidents: _____ injuries: _____ impacts: _____ postural stress: _____ difficult birth:_____ physical abuse: _____

other specify: _____

## Overall Emotional Stress/Trauma

loss of loved one:_____ legal concerns:_____ work stress:_____ Financial stress:_____ stress from being ill:_____

rapid life change in home school/job:_____ relationship:_____ separation/divorce :_____ mental emotional abuse:_____

## Overall Chemical Stress/Trauma

drugs:_____ smoke:_____fumes:_____alcohol:_____caffenine:_____allergies:_____chemical exposure:_____ food additives:_____

anesthesia:_____ perfumes/colognes:_____ Other:_____

When stressed, how do you "center yourself" or "Regroup"? _____

## Your specific needs and hopes for help in this office

In a published study pf over 2,800 patients in Network Spinal Analysis Care, conducted at the university of California, Irvine Medical College; 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 this office?

**0 = Does Not Apply to Me** **1=Not As Important to Me** **2=Important to Me** **3=Very Important to Me**

_____ Improvement of my Physical Symptoms.
_____ Improvement of Emotional/Mental Symptoms.
_____ Improvement of my Ability to React or Respond to Stress.
_____ Overall improvement in Quality of Life.
_____ **Other: Help us to better understand you, your history and needs that has not been addressed in this survey?**

_____

What do you hope to receive from Network Care in this office?_____

How will you know if your expectations have been meet?_____

What would motivate you to tell others about the care you receive in this office, and to encourage others to be under network care?_____

## General Physical & Medical History

Have you ever injured your spine (Neck, Back, Hips) ? **Y N**
Date of most significant injury:_____Describe:_____

Date of most recent injury:_____Describe:_____
Have you ever been in an auto accident? **Y N** Past Year ____ Within 5 Yrs._____ Over 5 Yrs._____
Describe: _____

Have you had any other injures (Job Sports Etc.)? **Y N** Past Year ____ Within 5 Yrs._____ Over 5 Yrs._____
Describe: _____
Have you had spinal x-rays, CAT scans or MRI's of your spine (head, neck, back, hips)? If yes when?_____
What were you told about them?_____ Where are the films now?_____
Have you had any surgeries? **Y N** Desribe:_____
Have you had any surgeries? **Y N** Desribe:_____
Have you had any broken bones or significant sprains? **Y N** Describe:_____
Have you ever been hospitalized? **Y N** **Past Year ____ Within 5 Yrs._____ Over 5 Yrs._____**
Describe: _____
Are you aware if your birth was? Traumatic ___ Breech ___ C-Section ___ Prolonged ___ Cord around Neck _____
Describe: _____
Do you exercise regularly? Y N If yes, what kind:_____

**FEMALES ONLY:**
Date of last Mammogram:_____ Normal:_____ Abnormal:_____
Date of last PAP:_____ Normal:_____ Abnormal:_____
Age Onset Periods:_____ Age Onset Menopause:_____
Periods Regular? Y N
Number of pregnancies:_____

Please ***circle*** all that apply

## PAST illnesses of yourself and family

| | | |
|---|---|---|
| Alcoholism | You | Family |
| Anemia | You | Family |
| Asthma | You | Family |
| Cancer/Tumor | You | Family |
| Diabetes | You | Family |
| Drug Abuse | You | Family |
| Depression | You | Family |
| Epilepsy/Seizures | You | Family |
| Glaucoma | You | Family |
| Heart Disease | You | Family |
| High Blood Pressure | You | Family |
| Kidney Disease | You | Family |
| Liver disease | You | Family |
| Hepatitis | You | Family |
| Lung Disease | You | Family |
| Mental illness | You | Family |
| Osteoarthritis | You | Family |
| Osteoporosis | You | Family |
| Phlebitis | You | Family |
| Rheumatic Arthritis | You | Family |
| Stroke | You | Family |
| suicide attempt | You | Family |
| Thyroid disease | You | Family |
| Tuberculosis | You | Family |
| Ulcer in GI tract | You | Family |
| Venereal disease | You | Family |
| High Cholesterol | You | Family |
| HIV/Immune DX | You | Family |

**Other:**_____

## Answer Yes or No as theses relate to your health

| | | |
|---|---|---|
| **CONSTITUTION** | | |
| weight loss | **Y** | **N** |
| fatigue | **Y** | **N** |
| Fever | **Y** | **N** |
| **Eyes** | **Y** | **N** |
| Glasses/contacts | **Y** | **N** |
| Eye Pain | **Y** | **N** |
| Double Vision | **Y** | **N** |
| Cataracts | **Y** | **N** |
| **EAR/NOSE/THROAT** | | |
| Difficulty hearing | **Y** | **N** |
| Ringing in Ears | **Y** | **N** |
| Vertigo | **Y** | **N** |
| Sinus Trouble | **Y** | **N** |
| Nasal stuffiness | **Y** | **N** |
| Frequent Sore throat | **Y** | **N** |
| **CARDOVASCULAR** | | |
| Murmur | **Y** | **N** |
| Chest pain | **Y** | **N** |
| Palpitations | **Y** | **N** |
| Dizziness | **Y** | **N** |
| Fainting spells | **Y** | **N** |
| Short of breath | **Y** | **N** |
| Difficulty lying flat | **Y** | **N** |
| Swelling Ankles | **Y** | **N** |
| **ENDOCRINE** | | |
| Loss of hair | **Y** | **N** |
| Heat/Cold intolerance | **Y** | **N** |
| **RESPITORUY** | | |
| Cough | **Y** | **N** |
| Coughing Blood | **Y** | **N** |
| Wheezing | **Y** | **N** |
| Chills | **Y** | **N** |
| **GASTROINTESTINAL** | | |
| Heartburn reflux | **Y** | **N** |
| Nausea/Vomiting | **Y** | **N** |
| Constipation | **Y** | **N** |
| Change in BM | **Y** | **N** |
| Diarrhea | **Y** | **N** |
| Jaundice | **Y** | **N** |
| Abdominal pain | **Y** | **N** |
| Black/Bloody BM | **Y** | **N** |

| | | |
|---|---|---|
| **GENITOURNARY** | | |
| Burning/Frequency | **Y** | **N** |
| Nighttime | **Y** | **N** |
| Blood in urine | **Y** | **N** |
| Erectile dysfunction | **Y** | **N** |
| Abnormal discharge | **Y** | **N** |
| Bladder leakage | **Y** | **N** |
| **ALLERGIC/IMMUNOLOGIC** | | |
| Hives/Eczema | **Y** | **N** |
| Hay Fever | **Y** | **N** |
| **PSYCHATRIC** | **Y** | **N** |
| Anxiety/Depression | **Y** | **N** |
| Moos swings | **Y** | **N** |
| Difficult sleeping | **Y** | **N** |
| **HEMOTOLOGY/LYMPH** | **Y** | **N** |
| Easy bruising | **Y** | **N** |
| Gums bleed easily | **Y** | **N** |
| Enlarged glands | **Y** | **N** |
| **MUSCULOSKELETAL** | **Y** | **N** |
| Joint pain/swelling | **Y** | **N** |
| Stiffness | **Y** | **N** |
| Muscle pain | **Y** | **N** |
| Back pain | **Y** | **N** |
| **SKIN** | **Y** | **N** |
| Rashes/Sores | **Y** | **N** |
| Lesions | **Y** | **N** |
| Itching/Burning | **Y** | **N** |
| **NEUROLOGICAL** | **Y** | **N** |
| Loss of strength | **Y** | **N** |
| Numbness | **Y** | **N** |
| Headaches | **Y** | **N** |
| Tremors | **Y** | **N** |
| Memory Loss | **Y** | **N** |
| | **Y** | **N** |