All About YOU Profile

Please bring this completed health profile with you to our first visit. It will give me an opportunity to better understand you, your concerns, and additional factors which may affect your health and how I analyze and adjust your spine. At our first visit, you and I will go over this form together and discuss any additional questions that may arise from your comments noted here.

Thank you and I look forward to meeting you!

Dr. Jenny Dubisar

First Name ____________ Last Name ____________ Today's Date ____________

Your E-mail ____________

Address ____________

City ____________ State ______ Zip ________ Date of Birth ____________

❒ Home Phone ____________ ❒ Work Phone ____________ ❒ Mobile Phone ____________

(Please check your preferred contact number) ❒ May I text you?

Do you have children? ❒ Yes ❒ No

If yes, what are their names and ages? ____________

Your Profession: ____________

How did you discover this office and the professional services offered? ____________

What do you know about what we do? ____________

Part 1: Your involvement in your health, and any health concerns you may have:

1. Share with me a little of what is going on in your life currently? ____________
2. If applicable, do you currently have any health concerns, or have you had any health concerns in the past? ____________
   a) When did this situation begin? ____________
   b) Have you ever experienced this health challenge previously? ____________

c) If applicable, please grade the level to which this health concern (s) has on your overall quality of life and health. Please use the following scale of 1-4;

1 being a mild affect, and 4 is a significant effect.

Affect on work	❍ None	❍ 1	❍ 2	❍ 3	❍ 4
Affect on exercise	❍ None	❍ 1	❍ 2	❍ 3	❍ 4
Affect on Social Life	❍ None	❍ 1	❍ 2	❍ 3	❍ 4
Affect on Recreation /Play	❍ None	❍ 1	❍ 2	❍ 3	❍ 4
Affect on Walking	❍ None	❍ 1	❍ 2	❍ 3	❍ 4
Affect on Eating	❍ None	❍ 1	❍ 2	❍ 3	❍ 4
Affect on Rest/Sleep	❍ None	❍ 1	❍ 2	❍ 3	❍ 4
Affect on Sitting	❍ None	❍ 1	❍ 2	❍ 3	❍ 4
Affect on Overall Concern about Health	❍ None	❍ 1	❍ 2	❍ 3	❍ 4
Awareness of Concern During the Day	❍ None	❍ 1	❍ 2	❍ 3	❍ 4
Awareness of Concern During the Night	❍ None	❍ 1	❍ 2	❍ 3	❍ 4

d) Have any of your other family members ever had a similar health concern? ________________

____

e) Why do YOU think this has happened or continues to happen? ___________________________

____

There are 3 aspects to health: Physical, Chemical, and Emotional. When completing the next segment, please keep in mind that even minor stressors in these three primary areas add up over time, or combine to create interesting concoctions in your body. Be thorough in your own assessment of these three areas of your health, and consider them from birth to present as much as possible. You may want to add additional comments on a separate page.

Part 2: Health/Trauma/Medical/Healing History:

1. Have you ever been injured at work or had any kind of vehicular accident(s)? ❒ Yes ❒ No
   a. If Yes, please explain: ____

   ____

2. Have you ever experienced trauma to your spine (Head, Neck, Back, Hips)? ❒ Yes ❒ No
   a) Date of most significant injury: ____
   b) What happened? ____

   ____

   c) Date of most recent injury: ____
   d) What happened? ____

   ____

3. In what position(s) do you typically sleep? ____
4. Do you consult with a physician for other than routine evaluations? ❒ Yes ❒ No
   a) If Yes, please explain: ____

   ____

   ____

5. Have you consulted with ANY health care provider in the past six months?
   ❒ Yes ❒ No

   If Yes, please state why: ____

6. Please list all nutritional supplements/Vitamins/herbs that you take regularly: ________________

   ____

7. Please list any medications that you are currently taking, or may have possibly taken over this past year, and please state the reason for taking them: ____________________________________

   ____

8. In your past, have you ever taken medication for a period of three months or longer? ❒ Yes ❒ No
   a) If Yes, what was the reason for taking this medication? ________________________________

   ____

9. Do you regularly utilize aspirin, Advil, Tylenol, sleeping pills, Motrin, etc.? ❒ Yes ❒ No
   a) If Yes, please state the reason for taking this medication: ________________________________

   ____

10. Have you ever had any x-rays, Cat Scans, or MRI Images taken of your spine (Head, Neck, Back, or Hips)?
   ❒ Yes ❒ No
   a) If Yes, please specify: ____

   ____

   b) What were you told about these films/x-rays? ________________________________

   ____

   c) Where are these x-rays now? ____

11. Do you have all of your body parts? ❒ Yes ❒ No ____

12. Have you ever had any surgeries? ❒ Yes ❒ No ____

13. Please list any bones that you have broken or any part of your body that you have severely strained/sprained: ____

   ____

14. Has your spine ever been professionally addressed by a chiropractor or other spinal practitioner?
   ❒ Yes ❒ No
   a) If Yes, by whom and when? ____

   ____

   b) Why did you go? ____

   ____

Are you still going? ❒ Yes ❒ No If No, when was your last adjustment: _________________

Does your family receive chiropractic care? ❒ Yes ❒ No

Part 3: The Stress Survey

Please rate your overall lifetime cumulative level of stress in each category from one to five, <u>one being minimal stress and five the highest level of stress</u>. Then, check all experiences that may apply to you under each category. In general, consideration of the current stressors is going to be more relevant to your immediate care, although exposure to certain stressors during the developmental years may have a significant effect on your current ability to adapt to stress.

1. Cumulative Physical Stress/Trauma

❍ 1 ❍ 2 ❍ 3 ❍ 4 ❍ 5

(Check those that apply):
❒ Falls
❒ Accident/ injuries
❒ Repeated postural stress
❒ Impacts
❒ A difficult birth (your own birth)
❒ A difficult birth/labor (your children)
❒ Pregnancy/Pregnancies
❒ Physical Trauma/Abuse
❒ Awkward work hours
❒ Driving Stress
❒ Sports activities
❒ Baby-wearing/carriers

2. Cumulative Chemical Stress:

❍ 1 ❍ 2 ❍ 3 ❍ 4 ❍ 5

(Check those that apply):
❒ Exposure to smoke
❒ Fumes
❒ Chemicals at work
❒ Food additives
❒ Cigarette smoke
❒ Medication(s)
❒ Dehydration

3. Cumulative Emotional/Mental Stress:

❍ 1 ❍ 2 ❍ 3 ❍ 4 ❍ 5

(Check those that apply):

- ❒ Loss of loved ones
- ❒ Significant life changes
- ❒ Mental
- ❒ Emotional
- ❒ Sexual Abuse
- ❒ Legal concerns
- ❒ Financial concerns
- ❒ Move of home/school
- ❒ Separation/Divorce
- ❒ Relationship stress
- ❒ Stress of being ill
- ❒ Single parent

Is there anything else which may help us better understand you? ____

____

____

Thank you for the opportunity to serve you. I know your body already knows what it needs to do. Together, we can help you reach your optimal potential!

Warmly,

Dr. Jenny

A referral is the best compliment… if you appreciate the care you have received in our office, please share with others. If there is an issue to be addressed, constructive criticism along with potential solutions will be graciously received.

Please note the following policies and procedures in our office:

***Cancellation Policy**: Our policy is to request 24 hours notice of cancellation via voicemail, email or text message as this office is only able to serve clients through advance-scheduling. As a courtesy, we will text appointment reminders between 9am-10am on the day of your appointment. Any cancellation provided with less than a 3 hour notice may be subject to a $25 fee at the next appointment.*
Please sign here that you have read and understand our cancellation policy: ____________________

***Permissions Policy:** If this office is providing co-care for a client (for example, with a specific Midwife, OB/GYN, Doula, Acupuncturist, or Massage Therapist) we would like to have permission to share pertinent information relating to your care in this office. Please sign here if you give your permission for Dr. Jenny to share relevant information with your other health care provider(s):*

__________________________________ (If you decline, please write ‘Decline’ with your initials)