547 Pitney Road
Galloway, NJ 08205

Transformational Wellness Center

Comprehensive Health Profile

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transformationalwellnesscenter.com

Date		Date of birth
Last name	First Name	
Address	City, State, Zip	
Home phone	Work phone	Cell phone
Email	occupation	

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

Do you have a current health/life situation or concern? If so, please describe

When did this situation or concern begin?

Have you done anything about this concern, or been given any advice or treatment for it? ☐ yes ☐ no

If yes, what were you told?

What was done?

Did it seem to work?

Have your concerns changed?

Please grade the level to which this health concern(s) affects these aspects of your functioning/quality of life

0 affects me *very little*	1 affects me *slightly*	2 affects me *moderately*	3 affects me *drastically*

work	0 1 2 3	recreation/play	0 1 2 3	rest/sleep	0 1 2 3
social life	0 1 2 3	walking	0 1 2 3	sitting	0 1 2 3
exercise	0 1 2 3	eating/digestion	0 1 2 3	love/sex life	0 1 2 3

How aware are you during the day	0 1 2 3	How aware are you during the night	0 1 2 3
Concern about symptom	0 1 2 3	Concern about health	0 1 2 3

Comments:

Is there any activity during which you totally forget about this concern?

Is there a time of day which you are *more* aware of this concern? ☐ morning ☐ day ☐ evening ☐ night

Is there a time of day which you are *less* aware of this concern? ☐ morning ☐ day ☐ evening ☐ night

Why do you think this happened to you?

Do you think it's the sole cause? ☐ yes ☐ no | If no, what else might be involved?

Are you doing anything differently because of this situation/concern?

Since the development of this situation

Have you changed any habits? ☐ yes ☐ no | explain

Held or touched part of your body more often or differently? ☐ yes ☐ no

Moaned, cried, or made sounds that you usually do not make? ☐ yes ☐ no

Which best describes how you currently feel about yourself and your situation

A. I feel helpless, little or nothing works	B. This is terrible, I am scared, I hope you can fix this
C I feel stuck and can't help myself right now	D. I deserve more than this, I would like your help

Have you ever injured your spine (neck, head, back, hips)? ☐ yes ☐ no

Date of most significant injury

What happened?

Date of most recent injury

What happened?

Please list medications (prescription and over the counter) you have taken within the past 60 days

1.	2.	3.
4.	5.	6.

In the past, have you taken medications for a period of more than three consecutive months? ☐ yes ☐ no

What did you take?

What was the reason for taking it?

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

1.	2.	3.

Please describe what your main diet includes

Have you had any surgeries? ☐ yes ☐ no	Please explain

Have you broken any bones, sprains? ☐ yes ☐ no	Please explain

Have you consulted a physician or other health care provider in the past three months? ☐ yes ☐ no

Please explain

Has your spine ever been professionally adjusted/manipulated/entrained? ☐ yes ☐ no

By whom?	When?
Why did you go?	Are you still going? ☐ yes ☐ no
What did he/she do for you?	Were you pleased? ☐ yes ☐ no

Have you received Network Spinal Analysis™ care? ☐ yes ☐ no

Has your family received Network Spinal Analysis™ care? ☐ yes ☐ no

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	Homeopathy
Osteopathy	yoga/tai chi/chi gong
Ayurvedic medicine	Rebirthing/breathwork
Acupuncture/oriental medicine	Nutritional counseling

- Chelation therapy
- Music/dance/sound/light/aromatherapy
- Physiotherapy/occupational therapy
- Emotional therapy/psychotherapy
- Somatorespiratory integration (SRI)

Please grade the following stresses in both *your entire history* and *your more recent history*

0 no awareness of stress	1 slightly stressful situation(s)
2 moderately stressful situation(s)	3 extremely stressful situations(s)

Complete history		More recent history	
Overall physical stress, trauma	0 1 2 3	Overall physical stress, trauma	0 1 2 3

Includes falls, accidents, injuries, repeated postural stress impacts, difficult birth, traction, physical abuse

Overall emotional/mental stress	0 1 2 3	Overall emotional/mental stress	0 1 2 3

Includes loss of loved ones, raid change in life situation(s), mental, emotional, sexual abuse, legal concerns
Financial concerns, move of home/school, divorce or separation of relationship, stress of being ill

Overall chemical stress	0 1 2 3	Overall chemical stress	0 1 2 3

Includes drugs, smoke, fumes, food additives, etc.
Comments:

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 experiences, family, work, recreation, past injuries, genetics, dietary program, exercises, outlook, etc. that you feel impair your opportunity for full glowing health?

Are there any particular factors or elements about your life experiences, family, work, recreation, past injuries, genetics, dietary program, exercises, outlook, etc. that you feel give you an edge or add to your health?

Any additional information you would like to let us know:

Thank you for choosing Transformational Wellness Center where we practice Network Spinal Analysis™. 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 toward greater health and wellness.