Dr. Jessica Rose, D.C.

Awakening Hearts, Inc.

Client Health History

Name:_____ Date:_____
(First) (Middle) (Last)

Street Address:_____ City/zip:_____

Best phone: H W C_____ Gender: _____

Date of Birth:_____ Marital Status:_____ Email:_____

Emergency Contact:_____ Phone:_____ Relationship:_____

How did you hear about our office?:_____

Please offer yourself the gift of your presence as you reflect upon your health and well-being.
This will support us both during our time together.
~Thank you~

1. Please share the health and wellness pieces that you would like support with:_____

_____

2. What would you like to receive from this care? _____

_____

3. Is there a time or activity that is very supportive to your well-being; or when you almost/totally forget about any referenced health pieces:_____

_____

4. Is there a time of day or activity that increases awareness of these pieces?_____

5. If your desired change were to occur tomorrow, what would be different about your life?_____

_____

7. Have you received previous support/ treatment for this situation or concern? Yes ❑ No ❑ If yes, when? What type of care did you receive? What were you told? What support did it offer?

_____

_____

8. Please grade the level any health piece(s) mentioned affects these aspects of your life:

0 - It does not seem to affect me. **2 - It seems to a moderately affect me.**
1 - It seems to slightly affect me. **3 - It seems to drastically affect me.**

Affect on work 0 1 2 3 Affect on exercise 0 1 2 3 Affect on rest/sleep 0 1 2 3 Affect on eating 0 1 2 3
Affect on social life 0 1 2 3 Affect on walking 0 1 2 3 Affect on sitting 0 1 2 3
Affect on recreation/play 0 1 2 3 Affect on love life 0 1 2 3 Concern about health 0 1 2 3

Comments: _____

9. Have any other family members had the same or similar health concerns, if applicable? Yes ❑ No ❑

10. Please list any prescription medications, over-the-counter medications, vitamins, and supplements that you are currently taking:_____

_____

11. Have you had spinal injuries (neck, head, back, hips), broken bones or significant sprains? Yes ❑ No ❑
Have you had a work- and/or auto-collision-related injury? Yes ❑ No ❑
If yes to either, when and what happened?_____

_____

12. Have you any Surgeries or been Hospitalized? Yes ❑ No ❑ If yes, for what reason and when? _____

_____

13. Has your spine ever been professionally adjusted? Yes ❑ No ❑
a) By whom and when? _____
b) Were you pleased? Yes ❑ No ❑ c) Are you still going? Yes ❑ No ❑

14. Do you consult a physician or another health care provider for other than routine evaluations? Yes ❑ No ❑
If yes, what is the reason for the visit(s) and when was your last visit? _____

_____

Stress Survey: Please grade the following stresses:
0 - no awareness of stress **1 - slight stress** **2 - moderate stress** **3 - extreme stress**

1. Overall Physical Stress: 0 1 2 3 Please **circle** those experienced **now** and <u>underline past experiences</u>:

falls accidents injuries repeated postural stress difficult birth traction

physical abuse severe fatigue sexual difficulties live births:# __ pregnancies:#__

Other:_____

2. Overall Chemical Stress: 0 1 2 3 Please **circle** those experienced **now** and <u>underline past experiences</u>:

prescription drugs over-the-counter drugs recreational drugs smoke fumes

pollutants food additives Other: _____

3. Overall Emotional/Mental Stress: 0 1 2 3 Please **circle** those experienced **now** and <u>underline past experiences</u>:

loss of loved one(s) rapid change in life situation mental abuse emotional abuse sexual abuse

legal concerns financial concerns move of home change in school stress of being ill

change in relationship with significant other grief depression anxiety nervousness

Other: _____

4. Have you experienced other significant traumas or events that have felt traumatic to you?

_____

_____

Lifestyle:

1. Occupation: _____ Employer: _____ Hours/Week: _____

   Do you enjoy work? Yes ❑ No ❑ Why/Why not?_____

2. Do you have an exercise, meditation, prayer, nutritional, or dietary program? Yes ❑ No ❑

   If yes, please describe: _____

   _____

3. Water consumption per day: _____

4. Nicotine/Alcoho1/Caffeine Use: _____

5. Interests and hobbies: _____

6. When stressed how do you "center yourself" or regroup? _____

7. Are there any particular elements about your life, experiences, family, work, recreation, past injuries, genetics, outlook etc. that you feel impair your opportunity for full glowing health?_____

   _____

8. Are there any particular elements about your life, experiences, family, work, recreation, past, genetics, outlook etc. that you feel support your opportunity for full glowing health?_____

   _____

Thank you for taking this step towards greater well-being.

I am excited and honored to support you on your journey.