THE VITALITY CENTER

CREATING STRATEGIES FOR EVOLUTION

Hello and thank you for inquiring about Network Spinal Analysis! Enclosed are some forms for you to complete and bring to your initial visit. This information will help us to become better acquainted with you so that we might support your goals for care.

The natural state of living things is ***ease***! Each of us is capable of finding our way back from physical, chemical, and emotional overloads to our natural state. This journey of returning to wellness is called ***healing***. Our purpose is to facilitate your healing process by removing interference from your nervous system so that your own innate healing capacity works at its fullest potential. We do this with gentle, honoring, specific contacts.

Clinical work and scientific studies have shown that people who receive regular network care enjoy:

- Stronger posture and spines that are softer and more supple
- Improved overall physical vitality: more energy, greater flexibility, reduced chronic pain, fewer colds and headaches
- Greater ability to cope with stress in the areas of health, family, relationships and work
- Improved emotional and psychological well-being
- Overall quality of life improvement

No matter what else we do for ourselves (diet, exercise, meditation, etc.), the body and mind function more effectively when there is greater clarity and less tension in the spinal system. There is no substitute for the Network Spinal Analysis entrainment.

We look forward to meeting you.

In Wellness,

Dr. Jane Arzt, D.C.

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telephone 510 654 1480 facsimile 510 654 1680 *email* jarzt_NCE@pacbell.net
www.networkvitalitycenter.com

DIRECTIONS TO:

The Vitality center

5901 CHRISTIE Avenue, SUITE 105
510 654 1480

FROM THE FREEWAY:
Highway Exit off 580/80 (East shore Freeway) is Powell Street/Emeryville. Head east on Powell Street. At the next intersection take a LEFT onto Christie Avenue. We are in the five-story building on the left behind the Kinko's that you will see as you turn onto Christie. If you look up, you will see '5901'. Make a left into the parking lot at 59th Street. The entrance to our building faces the bay or the freeway. We are located on the 1st floor, Suite 105 at the end of the hall. The nameplate will show our former name: Network Chiropractic of Emeryville.

FROM STANFORD AVENUE:
Take Stanford Avenue towards Emeryville – it turns into Powell Street. Follow Powell over the bridge that crosses the train tracks. At Christie Avenue take a RIGHT. We are in the five-story building behind the Kinko's that you will see as you turn onto Christie. If you look up, you will see '5901'. Make a left into the parking lot at 59th Street. The entrance to our building faces the bay or the freeway. We are located on the 1st floor, Suite 105 at the end of the hall. The nameplate will show our former name: Network Chiropractic of Emeryville.

Park anywhere it reads East Bay Park.

Comprehensive Health Profile

Date: _____ / _____ / _____

Name: _____ Occupation:_____
Address: _____
City: _____ State: _____ Zip: _____
Home Phone: (____)____-_____ Business Phone: (____)____-_____ Cell Phone: (____)____-_____
Email: _____ Date of Birth: ___ /___ /___ Height: ____' ____"
Marital Status: S M W D Number of Children: _____
Health Insurance: _____ Policy No: _____ Group No: _____

Who referred you to our office and the professional services we offer? _____
_____
Have you received any type of chiropractic care in the past? ☐Yes ☐No
Were you pleased with their care? ☐Yes ☐No If yes, why did you discontinue your chiropractic care? _____

PLEASE ANSWER THE FOLLOWING QUESTIONS ABOUT YOUR PERSONAL HISTORY

1) Do you currently have any health concerns? ☐Yes ☐No Please Describe: _____
_____
_____
_____

2) Please grade and circle the level to which this health concern(s) affects the following 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.**

Affect on Work	0 1 2 3	Affect on Recreation/Play	0 1 2 3
Affect on Rest/Sleep	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 Exercise	0 1 2 3	Affect on Eating	0 1 2 3
Affect on Love Life	0 1 2 3		

3) Have you done anything or sought treatment for this situation or concern? ☐Yes ☐No
If yes, what were told? _____
_____
4) What was done? _____
Did it seem to work? _____
5) What was different about **YOU**, after treatment? _____
_____
6) What was different about your **CONDITION** or **SYMPTOM** after treatment? _____
_____
7) Why do you think this has happened, or continues to happen, to you? _____
_____
Do you think this is the sole cause? ☐Yes ☐No If No, what else is involved? _____
_____

8) Which of the following BEST describes your current condition? (Please choose only **ONE**)
☐ I feel helpless; nothing works.
☐ I don't like what I am feeling, and I hope you can fix it.
☐ I feel this is a pattern that has happened to me before; it is 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 wellness.
9) What do you hope to receive from Network Care in this office? _____

OVERALL STRESS SURVEY

Please grade your Past/Current Life Stresses using the following scale:
0 - *No* awareness of stress **1 - *Slightly* stressful** **2 - *Moderately* stressful** **3 - *Extremely* stressful**

Overall Physical Stress/Trauma: 0 1 2 3
(includes: falls, accidents, injuries, repeated postural stress, impacts, difficult birth, physical abuse, loss of consciousness, broken/fractured bones, etc.)

Overall Emotional/Mental Stress: 0 1 2 3
(includes: loss of loved ones, rapid change in life situations, abuse, move of home/school, legal concerns, financial concerns, divorce, relationships, etc.)

Overall Chemical Stress: 0 1 2 3
(includes: prescription drugs, smoke, alcohol, caffeine, fumes, food additives, anesthesia from surgery, over-thecounter medications, etc.)

PHYSICAL HISTORY

BIRTH STRESS: Information about your birth history:
1) Did your mother have a difficult pregnancy with you? ☐Yes ☐No
2) Did she have any falls, accidents or physical injuries during pregnancy? ☐Yes ☐No
3) Was your birth traumatic? ☐Yes ☐No
4) Was your birth: ☐Drug induced ☐"C" Section ☐Prolonged
☐Forceps or Suction ☐Natural ☐Breech
☐Cord around Neck ☐Other: _____
5) Describe any other physical or mechanical stress to your mother or you as labor progressed, delivery progressed, or as a newborn:_____
GENERAL PHYSICAL TRAUMA:
6) Were you ever knocked unconscious? ☐Yes ☐No If Yes, how/when? _____

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7) Have you ever broken any bones? ☐Yes ☐No If Yes, which one(s)?_____

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8) Have you ever had any impacts, falls, or jolts that you feel specifically may have injured your spine?
☐Yes ☐No If Yes, how/when?_____
9) Have you ever injured your head, neck, back or hips? ☐Yes ☐No If Yes, how/when?

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10) Have you served in the military? ☐Yes ☐No If Yes, were you involved in combat?
☐Yes ☐No Details: _____
11) On average, how many hours per day do you participate in the following?
___Sitting ___Standing ___Desk Work ___Phone Work ___Computer Work
___Driving ___Manual Labor ___Lifting Heavy Objects ___Stooping/Bending/Kneeling

SPORTS OR LEISURE:

12) Were you, or are you active in any sport(s)? ☐Yes ☐No If Yes, which one(s)?

_____

13) Have you been hurt in any of these activities? ☐Yes ☐No If Yes, when/where?

_____

AUTOMOBILE ACCIDENTS:

14) Have you, (even as a passenger, even if you do not think you were hurt), been involved in a car accident, or near collision? Please list approximate dates and severity (Mild, Moderate, Extreme).
Automobile: _____

_____

Bus, bicycle, motorcycle, train, airplane, moped, or other vehicles: _____

_____

MEDICAL TREATMENT:

15) Have you ever been hospitalized? ☐Yes ☐No If Yes, what was done? _____

_____

16) Have you had surgery? ☐Yes ☐No If Yes, what was done? _____

_____

17) Do you have all of your body parts? ☐Yes ☐No If No, please describe: _____

_____

18) Have you ever had: ☐Spinal Tap ☐Spinal Injections ☐Physiotherapy ☐Neck Collar ☐ Spinal Brace ☐Traction ☐Heel Lift ☐X-Ray Treatments ☐Corrective Shoes or Bars ☐Extensive Diagnostic X-Rays ☐Acupuncture ☐Chemotherapy ☐Transfusion ☐Body Part in a Cast or Immobilized?

CHEMICAL HISTORY

BIRTH STRESS:

1) Was your mother regularly taking any drug immediately prior to, or during her pregnancy with you?
☐Yes ☐No If Yes, please explain _____
2) Did she use ☐Alcohol ☐Smoking ☐Other: _____
3) Was her labor chemically induced or altered? ☐Yes ☐No
4) During delivery, was your mother?
☐Conscious ☐Semi-Conscious ☐Unconscious ☐Under Spinal Anesthesia
5) Any other chemical stresses that your mother may have been subject to during pregnancy, labor, or delivery? _____

GENERAL CHEMICAL TRAUMA:

6) Are you **now** taking any drug(s) (prescription or over-the-counter) regularly? ☐Yes ☐No
If Yes, please list drug(s), when prescribed and reasons for taking them: _____

_____

_____

7) Were you previously taking any medication regularly? ☐Yes ☐No If Yes, which ones / how long?_____

_____

8) Do you now, or in the past, have a history of alcohol and/or drug abuse? ☐Yes ☐No
If Yes, please describe: _____
9) Do you, or did you, work with any chemical, fume, dust, powder, etc. for prolonged periods? ☐Yes ☐No If Yes, please describe _____
10) Please indicate how much of the following products you consume:
Alcohol: ___Drinks/Week Coffee: ___Cups/Day Tobacco: ____Cigarettes/Day
Soda: ____/Day Artificial Sweeteners ☐Yes ☐No If yes, which type:_____

EMOTIONAL HISTORY

BIRTH STRESS:

1) My birth was: ☐At Home ☐In a Birthing Center ☐In a Hospital ☐Other
2) Were you incubated or isolated after birth? ☐Yes ☐No
3) Were you: ☐Bottle Fed Formula ☐Bottle Fed Mothers Milk
☐Nursed - How Long? _____ ☐Nursed and Bottle Fed?

GENERAL EMOTIONAL TRAUMA:

4) For each of the following potential spinal stresses, indicate the severity either past or present:

Potential Spinal Stress/Tension Sources	PAST	PRESENT
Childhood Stress	☐Mild ☐Moderate ☐Extreme	☐Mild ☐Moderate ☐Extreme
School Stress	☐Mild ☐Moderate ☐Extreme	☐Mild ☐Moderate ☐Extreme
Family Stress	☐Mild ☐Moderate ☐Extreme	☐Mild ☐Moderate ☐Extreme
Personal Relationships	☐Mild ☐Moderate ☐Extreme	☐Mild ☐Moderate ☐Extreme
Stress of Being Sick	☐Mild ☐Moderate ☐Extreme	☐Mild ☐Moderate ☐Extreme
Work Stress	☐Mild ☐Moderate ☐Extreme	☐Mild ☐Moderate ☐Extreme
Stress of Commuting	☐Mild ☐Moderate ☐Extreme	☐Mild ☐Moderate ☐Extreme
Loss of Loved One(s)	☐Mild ☐Moderate ☐Extreme	☐Mild ☐Moderate ☐Extreme
Change in Lifestyle	☐Mild ☐Moderate ☐Extreme	☐Mild ☐Moderate ☐Extreme
Change in Vocation	☐Mild ☐Moderate ☐Extreme	☐Mild ☐Moderate ☐Extreme
Abuse (Verbal, Physical, Emotional, Sexual, etc.)	☐Mild ☐Moderate ☐Extreme	☐Mild ☐Moderate ☐Extreme

YOUR SPECIFIC NEEDS AND HOPES FOR CARE IN THIS OFFICE?

1) In a published study of Health and Wellness benefits for patients under Network Care (conducted at UC Irvine Medical School), patients reported an overall improvement in all of the categories listed below. How do you hope to benefit from care in this office?

A) ***Very important to me*** **B)** ***Important to me*** **C)** ***Not so important to me*** **D)** ***Does not apply***

a) _____ Improvement of my **Physical Symptoms.**
b) _____ Improvement of **Emotional/Mental Symptoms.**
c) _____ Improvement of my **Ability to React or Respond to Stress.**
d) _____ Improvement in **Enjoyment of Life** and the Ability to make **Healthier, more Constructive Choices.**
e) _____ Overall improvement in **Quality of Life.**

2) Is there anything else you may wish to share which may help me better understand you, your history, or your professional and personal needs which have not been discussed in this profile?

_____
_____

3) What would motivate you to tell others about the care you receive in this office and encourage others to get under Network Care? _____
_____
_____
_____