Embodied Brilliance
Dr. Jessica Rose, D.C.

Client Health History

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

Email:_____ Best phone: H / C_____

Street Address:_____ City/zip:_____

Date of Birth:_____ Marital Status:_____

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, wellness or transformational pieces that you would like support with:_____

_____

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

_____

3. Is there a time/ activity that supports your desired experience of well-being; or when you nearly forget about any referenced concerns? _____

_____

4. Is there a time of day/ activity that increases awareness of any referenced pieces? _____

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

_____

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

_____

_____

7. Please grade the level any health pieces(s) mentioned affect 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

8. Have any other family members had the same or similar health concerns? Yes ❑ No ❑ N/A ❑

If yes, please elaborate: _____

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

_____

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

_____

_____

11. Have you any surgeries or been hospitalized? Yes ❑ No ❑ If yes, for what reason and when? _____

_____

12. 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 ❑

13. Do you consult a physician or other health care provider for other than routine evaluations? Yes ❑ No ❑
If yes, what is the reason for the visits 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 current experiences and underline past experiences:

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 current experiences and underline past experiences:

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 current experiences and underline past experiences:

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 sexism racism depression anxiety

nervousness Other: _____

4. Please share any other significant traumas you have experience or events that have felt traumatic to you or your family of origin?_____

_____

_____

_____

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 self-sooth, "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.