Back to Life Wellness Center
Comprehensive Health Profile

We are here to offer you skills to live well!

208 Fairmount Avenue ● Philadelphia, PA 19123
215-928-8898
www.getbacktolife.org

Date		
Last Name	**First Name**	**Date of birth**
Address	**City, State, Zip**	
Home phone	**Work phone**	**Cell phone**
Email	**Occupation**	
Please list names of significant relationships (including children)		

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

What health/life situation concern(s) would you like attention to right now?

When did your first notice this situation or concern?

Do you have a belief/guess/knowledge of how this happened?

What else may be involved?

What actions have you taken prior to this visit to address your concern?

Did it seem to work?

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

How do you feel about these changes?

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

Please circle the activities that are affected by your concern and please rate your distress about it.

1 slight distress about it | **2 moderate distress about it** | **3 significant distress about it**

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

Comments:

Is there something that if you had more of it in your life – this concern might be diminished or alleviated?

Is there something that if you had less of it in your life – this concern might be diminished or alleviated?

Please circle what best describes how you **currently feel** about yourself and your situation:
optimistic, hopeful, curious, confused, concerned, worried, frustrated, angry, helpless, hopeless

Have you consulted a physician, therapist or other health care provider in the past six months?
☐ yes ☐ no
Please list and explain if you are continuing with care and what services they offer you.

Please rate the impact of the following stresses in both ***your life 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)

Life 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, sports, dance injuries
Comments:

Have you ever injured yourself physically?
Date of most **significant** injury:
What happened?

Date of most **recent** injury:
What happened?

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

Life history		**More recent history**	
Overall **emotional/mental** stress	0 1 2 3	Overall **emotional/mental** stress	0 1 2 3

Includes loss of loved ones, rapid 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
Comments:

Please comment on the quality of connection you have in the significant relationships in your life:

Life history		**More recent history**	
Overall **chemical** stress	0 1 2 3	Overall **chemical** stress	0 1 2 3

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

Please list medications you have taken in the past 6 months:

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

How do you feel about the effectiveness of these medications in adding to the quality your life?

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

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

How do you feel about the effectiveness of these in adding to the quality of your life?

Please describe what your main diet includes:

Do you drink alcohol? ☐ yes ☐ no	How often?

Do you...

Sleep well? ☐ yes ☐ no	comments:
Awaken rested? ☐ yes ☐ no	comments:
Spend time outside? ☐ yes ☐ no	comments:
Take vacations? ☐ yes ☐ no	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: