

Infinite Potential Centre

"The Centre for Empowerment, Wellbeing, Growth, and Evolution"

Confidential Personal History Questionnaire

OFFICE USE ONLY

Occp Ref Tracking

Email IPC BD Alarm

Date: ____ / ____ / 20__

Surname: _____ First Name: _____

Address: _____ Suburb: _____ State: _____ P/C _____

Home Ph: _____ Work Ph: _____ Mob: _____ Fax : _____

Email: _____ Date of Birth: _____ Age: ____ Male __ Female __

Occupation: _____ Blood Type: O A B AB unknown Relationship Status: _____

No. of Children ____ Age and Sex of each child _____

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

Since spinal cord tension results from the body's inability to adapt to any physical, chemical and emotional stress, it is extremely helpful for us to know as much as possible about your past and present stresses in all categories. Please answer these questions with as much detail as possible.

Have you ever had your spine and/or nervous system examined professionally? Yes No

If yes, when and by whom? _____

1. Do you have any current health concerns, symptoms or blocks that interfere with the quality of your life? If yes please describe.(What, where, when, for how long, etc): _____

2. Have you had experience with the following health, and/or healing modalities? **Which** have you tried, **when** and **for what** did you go, for **how** long and **what** were the results? (successful "S" or unsuccessful "U").

- Chiropractic _____
- Massage/Bodywork/Bowen _____
- Emotional therapy / Psychotherapy/Kinesiology _____
- Osteopathy/Cranial work _____
- Physiotherapy / Occupational Therapy _____
- Music/Sound/Light/Aromatherapy _____
- Homeopathy/ Naturopathy/ NES _____
- Ayurvedic Medicine _____
- Oriental Medicine/Acupuncture _____
- Nutritional Counseling/Therapy/Colonic Irrigation _____
- Oxygen Therapy/Chelation Therapy _____
- Reiki/Pranic/Theta Healing/Oneness _____
- Rebirthing/Breathwork _____
- Yoga/Movement/Dance/Tai Chi/Chi Quong/Tri Breath _____
- Somato Respiratory Integration _____
- NLP/The Forum/UPW/DWD/Holosync _____
- Family Constellations/Other _____

3. Do you exercise, meditate, and/or pray? Yes No
Please describe _____

4. When you get stressed, what do you do? _____

Physical Stress

Birth Stress

(Circle or tick the one that applies)

1. Was your mother outwardly ill prior to her pregnancy with you? Yes No
2. Did your mother have a difficult pregnancy with you? Yes No
3. Did your mother have any falls, accidents or any other physical injuries during pregnancy? Yes No
4. Was your birth traumatic? Yes No
5. Was your birth: drug induced assisted with forceps or suction
 C section (Caesarian) umbilical cord around the neck
 breech prolonged
 Natural Other: _____

Describe any other physical or mechanical stress to your mother or you as labor progressed, delivery progressed, or as a new born: _____

General

Please answer each topic with **Yes**, **No** or **N/A**. Please state **when** and **how** it occurred and **what** body part was injured (please include left or right side). Please rate the level of severity as **mild**, **moderate**, or **severe**. Please use the other side if necessary.

Did you ever?

1. Fall from the Cot or Pram _____
2. Fall down or up steps _____
3. Fall on ice _____
4. Have sport impacts _____
5. Have physical fights _____
6. Serve in the Armed Forces _____
7. Get knocked unconscious _____
8. Use crutches, a walker, or a cane _____
9. Fracture any bones _____
10. Severely sprain any joints _____
11. Have any impacts, falls, or jolts that you feel specifically have injured your spine _____
12. Have extensive dental and or orthodontic work performed _____
13. During the day I sit stand walk do desk work phone work drive do heavy lifting
14. I exercise: daily weekly monthly Describe: _____
15. Were you or are you active in any particular sport(s) Yes No
 Which one(s) presently: _____
 Which one(s) in the past: _____
16. Have you been hurt in any of these activities? Yes No
 What were the injuries: _____
17. Do you read for prolonged periods? Yes No
18. Do you play a musical instrument? Yes No Which one(s)? _____
19. Do you have a particular position for watching television? Yes No
 What position? _____
20. Do you wear: Glasses Bifocals Contact lenses N/A

Moving Vehicle Accidents

21. Have you ever (even as a passenger, even if you don't think you were hurt) been involved in a vehicular collision? Please list approximate dates, type of accident and severity (mild, moderate, extreme).

Automobile: _____

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

Medical Treatment

22. Have you ever been hospitalised? Yes No. If yes what was actually done to you and when? _____

23. Have you had surgery? Yes No. What was done to you and when? _____

24. Do you still have all your body parts? Yes No What is missing? _____

25. Have you had: spinal tap spinal injections neck collar spinal brace traction heel lift
 corrective shoes or bars on shoes x rays taken chemotherapy radiation therapy transfusions
 body part in a cast or immobilised?

Women please describe your menstrual cycle i.e. past/present, regularity, discomfort, use of pain killers and oral contraceptives etc. _____

Chemical Stress

Birth Stress

1. Was your mother regularly taking any drugs immediately prior to, or during her pregnancy with you? i.e. alcohol, smoking, medication, other? _____

2. Was her labor chemically induced or altered? Yes No

3. Was your mother: conscious semi conscious unconscious during your delivery

4. Any other chemical stress that your mother may have been subject to: _____

General Chemical Stress

5. Are you now taking any drugs (prescription, over the counter, or other)? Yes No Please list drugs, if prescribed, when prescribed and reason for taking them: _____

6. Have you been immunized or ever previously taken any drug? Yes No Please describe: _____

7. Do you or did you work with any chemical, fume, dust, powder, smoke for prolonged periods? Yes No

Describe: _____

8. Please grade any dietary selection that is appropriate for you using the following scale:

- O - do not consume this
- M – consume this monthly
- FM – consume this a few times per month
- FD – consume this a few times per day
- W – consume this weekly
- FW – consume this a few times per week
- D – consume this daily

- | | | | |
|--|--|--|----------------------------------|
| <input type="checkbox"/> Alcohol | <input type="checkbox"/> Dairy Products | <input type="checkbox"/> Beef | <input type="checkbox"/> Poultry |
| <input type="checkbox"/> Coffee | <input type="checkbox"/> Cooked Vegetables | <input type="checkbox"/> Lamb | <input type="checkbox"/> Fish |
| <input type="checkbox"/> Tobacco | <input type="checkbox"/> Raw Vegetables | <input type="checkbox"/> Fried Foods | <input type="checkbox"/> Seafood |
| <input type="checkbox"/> Artificial Sweeteners | <input type="checkbox"/> Fruit | <input type="checkbox"/> Weight control Diet | <input type="checkbox"/> Eggs |
| <input type="checkbox"/> Refined Sugars | <input type="checkbox"/> Whole Grains | <input type="checkbox"/> Organic Foods | <input type="checkbox"/> Soy |

The type of diet I usually follow I classify as: _____

Emotional Stress

Birth Stress (circle the one that applies)

1. My birth was: at home in a birthing centre in a hospital other _____
2. After birth were you: incubated isolated adopted Not applicable
3. Were you: bottle fed formula bottle fed mother’s milk breast fed breast fed and bottle fed
4. Order of Siblings (with gender and age ie: B(40), S(36), Me, B(33), S(29)): _____

General Emotional Stress

5. With the following emotional spinal stress situations, please put a **P** for a past or **C** for a current stress & rate the stress as mild, moderate, &/or extreme. (See example of a past moderate childhood stress)

	Mild	Moderate	Extreme
Childhood stress		P	

	Mild	Moderate	Extreme		Mild	Moderate	Extreme
Childhood stress				Work related stress			
School stress				Stress of commuting			
Play or Recreational				Loss of loved one			
Family stress				Change in lifestyle			
Personal relationships				Change in vocation			
Stress of being sick				Abuse			

Circle the one that applies

6. How do you grade your physical health? Excellent Good Fair Poor Getting Better Getting Worse
7. How would you grade your emotional health? Excellent Good Fair Poor Getting Better Getting Worse

What do you hope to receive from care at this centre?

With the 5 possible outcomes below, please rate each of them using this scale:

a) very important to me b) important to me c) not so important to me d) does not apply

- a b c d** Improvement of my physical symptoms.
- a b c d** Improvement of emotional/mental symptoms.
- a b c d** Improvement of my ability to react or respond to stress.
- a b c d** Improvement in enjoyment of life and the ability to make constructive choices.
- a b c d** Overall improved quality of life

What would you like to experience from attending our centre? Is there anything else that you would like to tell us: _____
