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Infinite Potential Centre

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

Confidential Personal History Questionnaire

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 **fo**r **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 Gong/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
☐ Vaginal	☐ Other: _____

Describe any other physical or mechanical stress to your mother or you as the birthing process 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 body application / dietary selection that is appropriate for you using the following scale:

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

___Alcohol	____Dairy Products	____Beef	____Poultry
___Coffee	____Cooked Vegetables	____Lamb	____Fish
___Tobacco	____Raw Vegetables	____Fried Foods	____Seafood
___Artificial Sweeteners	____Fruit	____Weight Control Diet	____Eggs
___Refined Sugars	____Whole Grains	____Organic Foods	____Soy
___Filtered Water	____Antiperspirants	____Fluoride Treatments	____ Fluoride Toothpaste

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 (Brothers/Sisters with 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: _____