essenceoflife
WELLNESS CARE

GENERAL INFORMATION

WELCOME!! Thank you choosing Essence of Life for your Wellness Care. We are committed to empowering you to make healthier lifestyle choices so you can live a more fulfilled and rewarding life.

NAME: _____ Today's Date: _____

Address: _____ Apt# _____

City: _____ Postal Code: _____

Telephone Home_____ Work _____ Cell_____

Email address: _____

Would you like to receive helpful information from our office through email? Y _____ N _____

Occupation_____

Date of Birth: _____/_____/_____ Marital Status: _____ #of children_____
day month year

What family members are currently under care in this office? _____

Who may we thank for referring you to our office? _____

Dr. Maureen Borghoff, DC, Bsc, CCWP
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COMPREHENSIVE WELLNESS PROFILE

Date: _____

About your Health: The human body is designed to be healthy. Throughout life, events occur which damage your natural health expression. This case history will uncover the layers of damage, especially to your nerve system, that resulted in poor health. Your care will be designed to correct these layers of damage and recover your innate health potential.

1) Do you have any health concerns? If so, please describe(if you need more room please use a separate sheet)
_____
_____
_____
2) When did this situation or concern begin?_____
3) Have you done anything about this situation or concern or gotten any advice or treatment for it? _____Yes ___ No
4) What was done?_____
_____
5) Did that seem to work?_____
_____

6) Please grade the level to which these health concerns affect these aspects of your functioning/quality of life.

0- No effect 1- Slight effects 2-Moderate effects 3-Drastic effects

Work	0	1	2	3	Recreation & Play	0	1	2	3	Rest /Sleep	0	1	2	3
Social Life	0	1	2	3	Walking	0	1	2	3	Sitting	0	1	2	3
Exercise	0	1	2	3	Eating	0	1	2	3	Love life	0	1	2	3
Concern about particular symptom/ condition	0	1	2	3						Concern about Health	0	1	2	3

7) How aware of this are you during the day? 0 1 2 3 at night? 0 1 2 3

8) Is there any time or activity you can be involved with in which you totally(or almost) forget about this condition, symptom or
concern?_____

9) Is there any time of day or activity which makes you aware of it?_____

10) Why do you think this has happened or continues to happen to you?_____
_____

11) If this condition or symptom were to go away tomorrow, what would be different about your life?
_____

12) What are you doing in your life now that is different than what you would be doing if you did not have this condition or symptom?_____

13) Are there any other symptoms or conditions you are living with, that were not discussed above? _____

_____

14) Which best describes your current feeling about yourself and your situation?

A) I feel helpless like little or nothing works
B) This is terrible, really bad, I am scared and hope you can fix it for me
C) I feel stuck, and can't help myself right now
D) I deserve more than what I have been experiencing and would like you to assist me in my healing
E) Other:_____

15) Are you looking for a quick fix to your problem or a more permanent solution?_____

Part 2: Your History

1) Have you ever been involved in a vehicular collision, or near collision (as driver or passenger)?_ yes _ no

2) Please list the approximate dates and whether the severity of the collision was mild, moderate or extreme.(include fender benders and other vehicular accidents-car, bus, bike, motorcycle, train etc.)

Date	**Type of Accident**	**Description of Injuries**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

3) Have you ever been hospitalized ? ___yes ___no

4) If yes, what was done there ? _____

_____

5) Have you had surgery ? ___yes ___no Please explain:_____

_____

6) Do you still have all your body parts ? ___yes ___no Please explain:_____

_____

7) Have you been diagnosed with any medical conditions?___yes ___no Please explain:_____

_____

8) What medications are you currently taking and why?_____

_____

_____

9) What herbs, nutritional supplements or natural home remedies are you taking regularly?

_____

_____

10) Please answer the following:

Exercise: Frequency_____ Type_____
Water: Amount per day _____ Type_____
Sleep: Average # of hours _____ Quality _____
Tobacco: Amount per day _____ In the past_____
Caffeine: Amount per day _____ In the past_____
Alcohol: Amount per week _____ In the past_____

11) Do you have daily bowel movements? ___Yes ___No, if not how often?_____

Birth Stress

11) Was your mother outwardly ill prior to her pregnancy with you ? ___ yes ___no___don't know
12) Did your mother have a difficult pregnancy with you ? ___ yes ___no___don't know
13) Did your mother have any falls, accidents or physical injuries during pregnancy ?___ yes ___no
14) Was your birth traumatic ? ___ yes ___no __ don't know
15) Was your birth: __drug induced __natural __ C section __forceps or suction

__ breech __prolonged __other_____

16) Did your mother smoke, drink alcohol or take medication while pregnant with you? ___ yes ___no ___don't know
17) Do you have an exercise, mediation, prayer, nutritional or dietary program? ___ yes ___ no
18) When stressed, how do you "centre yourself" or "regroup"?

_____

19) Have you had experience with the following health, treatment or healing modalities? Please circle:

Massage/Bodywork, Meditation, Yoga/Tai Chi/Chi Gong, Osteopathy/Craniosacral. Emotional/Psychotherapy, Homeopathy/Herbalist, Nutritional Counseling, Acupuncture/Traditional Chinese Medicine, Breath Work

Other (please describe)_____

Part 3: Stress Survey

With each of the following stresses that may be affecting your nervous system, please check either **"P"** for past or **"C"** for current. These stresses may play a role in ALL symptoms, disease and discomfort.

	MILD		MODERATE		EXTREME	
	P	C	P	C	P	C
Childhood Stress	___	___	___	___	___	___
School Stress	___	___	___	___	___	___
Play/Recreational Stress	___	___	___	___	___	___
Family Stress	___	___	___	___	___	___
Personal Relationship Stress	___	___	___	___	___	___
Stress of Being Sick	___	___	___	___	___	___
Work Related Stress	___	___	___	___	___	___
Stress of Commuting	___	___	___	___	___	___
Loss of a Loved one	___	___	___	___	___	___
Change in Lifestyle	___	___	___	___	___	___
Change in Vocation	___	___	___	___	___	___
Abuse (physical/mental/emotional/ sexual)	___	___	___	___	___	___

Part 4: Your Specific Needs and Hopes in this Office

1) Is there some aspect of your life that very much pleases you, brings you joy, or helps you to feel better about yourself ?

2) Are there any particular factors or elements about your life that you feel give you an edge, or add to your health ?

3) Is there any area of your life (work, family, dietary, etc.) that you feel would impair your opportunity to reach full flowing health?

4) Is there anything else you may wish to share which may help us to better understand you, your history, or your professional needs which have not been discussed on this survey ? Please explain:

5) If we were meeting 1 year from today, looking back over those 12 months, what has to have happened during that period for you to feel like you were optimizing your health and living a more fulfilling and rewarding life?

6) When communicating to you about your spine, nervous system, health and wellness (check your preference)

___Mostly speak with me about the clinical finding and tell me the changes I am making

___Mostly show me in written form the clinical findings, and let me see the changes that I am making

___Mostly let me get a sense of the clinical work, help me feel the difference in my body

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Part 3A: Time Line Worksheet

Below there are two timelines 1)Physical and 2) Emotional. For "1" please indicate any prescription and drug use major illnesses, root canals, or chronic conditions. For "2" please indicate any events in your life that were a drastic change for you, traumatic, sad, frightening such as deaths, divorce, accidents or moving from home to home. Be as thorough as you are able. Your infancy is just as pertinent as your adult life. It may help to write diagonally to fit information in.

<what happened

Physical Health Chronology

<meds, drugs or other

<what happened

Emotional Health Chronology

<treatment where app.

Name:_____

Please check all symptoms you have ever had, even if they do not seem related to your current problem and check the box where you fit on the chart. Your doctor will then be able to recommend what type of care you need to achieve balance . . .
Where are your loved ones?

BALANCED NERVOUS SYSTEM

☐ High Energy ☐ Few Symptoms ☐ Resistant to Infections ☐ Positive Mental Attitude
☐ Mentally Alert ☐ Excellent Health ☐ Active ☐ Vibrant

☐

UNBALANCED NERVOUS SYSTEM

UNDER-AROUSED

- ☐ Poor Attention
- ☐ Impulsive
- ☐ Easily Distracted
- ☐ Disorganized
- ☐ Depressed
- ☐ Lacking motivation
- ☐ Poor Concentration
- ☐ Spaciness
- ☐ Constipation
- ☐ Low pain threshold
- ☐ Difficulty waking
- ☐ Worry
- ☐ Irritable
- ☐ Low energy

☐

Low

Moderate

Severe

UNSTABLE

- ☐ Migraines
- ☐ Headaches
- ☐ Seizures
- ☐ Sleepwalking
- ☐ Hot flashes
- ☐ PMS
- ☐ Food sensitivities
- ☐ Bed wetting
- ☐ Eating disorders
- ☐ Bipolar disorders
- ☐ Mood swings
- ☐ Panic attacks

☐

Low

Moderate

Severe

OVER-AROUSED

- ☐ Cold hands
- ☐ Cold feet
- ☐ Tight Muscles
- ☐ Teeth grinding
- ☐ Anxiety
- ☐ Heart palpitations
- ☐ Restless sleep
- ☐ Poor expression of emotions
- ☐ Poor immune system
- ☐ Racing mind
- ☐ High blood pressure
- ☐ Accelerated aging
- ☐ Irritable bowel

☐

EXHAUSTED NERVOUS SYSTEM

☐ Cancer ☐ Rheumatoid Arthritis ☐ Diabetes ☐ Multiple Sclerosis ☐ Depression
☐ Chronic Fatigue Syndrome ☐ Fibromyalgia ☐ ALS ☐ Epstein-Barr Syndrome

☐

Compiled from the work By Siegfried Othmer, Susan F. Othmer, and David A. Kaiser EEG Biofeedback: A Generalized Approach to Neuroregulation

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Integrated Wellness Scorecard™

Your Integrated Wellness Scorecard

Name: _____ **Date:** _____

To help you clearly understand your current situation, try *The Integrated Wellness Scorecard*™. Rate your reactions to each pair of phrases. Decide where you lie on the scale from 1 to 10. Add up your total from each column.

I am unclear as to how I should stay healthy & vibrant	1	2	3	4	5	6	7	8	9	10	I have a clear, well-defined vision of how to stay healthy & vibrant
I do not have a clear action plan to achieve and/or maintain my health	1	2	3	4	5	6	7	8	9	10	I have a clear action plan to achieve and/or maintain my health
I do not know how to make the best health choices so I can live a more fulfilling life	1	2	3	4	5	6	7	8	9	10	I am empowered to make the right health choices for living a more fulfilling life
I don't have a clear life direction and I don't really know what I really want out of life	1	2	3	4	5	6	7	8	9	10	I have a clear direction in my life & understand what I really want out of life
I feel stress from the outside pressures of life	1	2	3	4	5	6	7	8	9	10	I worry less about stressful situations and know how to deal with daily pressures
I often suffer from stiffness, headaches, pain or get sick	1	2	3	4	5	6	7	8	9	10	I have gotten to the root of my discomfort and feel my immune system is functioning at an optimum level
I am not eating properly	1	2	3	4	5	6	7	8	9	10	I have a healthy diet
I feel like life is always on the go	1	2	3	4	5	6	7	8	9	10	I set aside enough time for myself during the week just to relax
I feel fatigued and don't have the energy I need to do the things I desire	1	2	3	4	5	6	7	8	9	10	I have an abundance of energy to do the things I desire
I lack inspiration in my life	1	2	3	4	5	6	7	8	9	10	I feel joy in all aspects of my life
ADD COLUMN TOTALS											YOUR SCORE _____