



Thank you for your interest in health, healing, and the Inner Wisdom Healing Studio. Congratulations upon your first step in a profound, new healing model: Network Spinal Analysis.

At the Inner Wisdom Healing Studio, you will explore the incredible healing power of your own body while learning to develop long-term strategies for taking care of your own health.

Your initial visit to the Inner Wisdom Healing Studio will include a consultation, a computerized comparative thermographic evaluation (temperature measurements), a computerized, noninvasive, surface-EMG (surface-electromyographic) study, an in-depth spinal analysis to determine where there may be disturbances in the natural transmission of messages from your mind to your body and your body back to your mind, and your first, gentle entrainment.

This package includes:

- ✓ *History* form
- ✓ A map to the office.

To prepare for your initial office visit, please follow this checklist:

- Thoroughly complete and sign the History form before coming to the office.
- Plan to spend up to 1 hour in the office for your initial visit
- Please be on time for your appointment.

Your journey towards greater health and awareness begins with a very gentle entrainment of your nervous system. This consists of soft touches to your spine and adjacent soft tissues. Our objective is to enhance your neural and spinal integrity. No matter where you are in your experience; whether you wish to rid yourself of a pain, a symptom, or a disease, or you wish to grow beyond your present level of awareness, with a clear, flexible nervous system, you are on your way. I look forward to meeting you for your initial evaluation.

Warmest regards,

Dr. Anne Jenkins and Staff

Dr. Anne Jenkins, D.C.

P.S. Please remember to bring your completed paperwork with you.

PHYSICAL HISTORY

BIRTH STRESS: Information about your birth history:

- 1) Did your mother have a difficult pregnancy with you? Yes No
- 2) Did your mother have any falls, accidents or physical injuries during pregnancy? Yes No
- 3) Was your birth traumatic? Yes No
- 4) Was your birth: Drug induced Forceps or Suction Prolonged
 "C" Section Cord around the neck Breech
 Natural Other: _____
- 5) Describe any other physical or mechanical stress to your mother or you as labor progressed, delivery progressed, or as a newborn: _____

GENERAL PHYSICAL TRAUMA:

- 6) Were you ever knocked unconscious? Yes No How/When? _____
- 7) Have you ever broken any bones? Yes No Which Ones? _____
- 8) Have you ever had any impacts, falls, or jolts that you feel specifically may have injured your spine? Yes No
How / When? _____
- 9) Have you ever injured your head, neck, back or hips? Yes No How/When? _____
- 10) Have you served in the military? Yes No If yes, were you involved in combat? Yes No
- 11) On average, how many hours per day do you participate in the following? __Sitting __Standing __Desk Work
__Phone Work __Computer Work __Driving __Lifting Heavy Objects __Manual Labor __Stooping/Bending/Kneeling

SPORTS OR LEISURE:

- 12) Were you, or are you active in any sport(s)? Yes No Which One(s)? _____
- 13) Have you been hurt in any of these activities? Yes No Where? _____

AUTOMOBILE ACCIDENTS:

- 14) Have you, (even as a passenger, even if you do not think you were hurt), been involved in a car accident, or near collision? Please list approximate dates and severity (Mild, Moderate, Extreme).

Automobile: _____

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

MEDICAL TREATMENT:

- 15) Have you ever been hospitalized? Yes No If yes, what was done to you? _____
- 16) Have you had surgery? Yes No If yes, what was done to you? _____
- 17) Do you have all of your body parts? Yes No If no, please describe: _____
- 18) Have you ever had: Spinal Tap Spinal Injections Physiotherapy Neck Collar Spinal Brace Traction
 Heel Lift X-Ray Treatments Corrective Shoes or Bars Extensive Diagnostic X-Rays
 Acupuncture Chemotherapy Transfusion Body Part in a Cast or Immobilized?

CHEMICAL HISTORY

BIRTH STRESS:

- 1) Was your mother regularly taking any drug immediately prior to, or during her pregnancy with you? Yes No
 - 2) Did she use Alcohol Smoking Other: _____
 - 3) Was her labor chemically induced or altered? Yes No
 - 4) Was your mother: Conscious Semi-Conscious Unconscious during delivery Under spinal anesthesia during delivery?
 - 5) Any other chemical stresses that your mother may have been subject to during pregnancy or labor? _____
- _____

GENERAL CHEMICAL TRAUMA:

6) Are you now taking any drug(s) (prescription or over-the-counter) regularly? Please list drug(s), when prescribed and reasons for taking them:

7) Were you previously taking any medication regularly? Which Ones / How Long? _____

8) Do you now, or in the past have a history of alcohol / drug abuse or heavy use? Yes No

Please describe: _____

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

10) Please indicate how much of the following products you consume:

Alcohol - Drinks/Week: _____ Coffee – Cups/Day: _____ Tobacco – Amount/Day: _____
 Artificial Sweeteners Yes No Soda - #/Day: _____ Refined Sugar – Candy/Pastries/Day: _____

EMOTIONAL HISTORY

BIRTH STRESS:

- 1) My birth was: At Home In a Birthing Center In a Hospital Other
- 2) Were you incubated or isolated after birth? Yes No
- 3) Were you: Bottle Fed Formula Bottle Fed Mothers Milk Nursed - How Long? _____ Nursed and Bottle Fed?

GENERAL EMOTIONAL TRAUMA:

4) With each of the following potential spinal stress situations, please indicate the severity either past or current.

Potential Spinal Stress/Tension Sources	PAST			CURRENT		
Childhood Stress	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Extreme	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Extreme
School Stress	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Extreme	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Extreme
Family Stress	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Extreme	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Extreme
Personal Relationships	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Extreme	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Extreme
Stress of Being Sick	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Extreme	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Extreme
Work Stress	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Extreme	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Extreme
Stress of Commuting	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Extreme	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Extreme
Loss of Loved One	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Extreme	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Extreme
Change in Lifestyle	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Extreme	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Extreme
Change in Vocation	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Extreme	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Extreme
Abuse (Verbal, Physical, Emotional, Sexual, etc)	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Extreme	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Extreme

YOUR SPECIFIC NEEDS AND HOPES FOR HELP IN THIS OFFICE?

- A) *Very important to me* B) *Important to me* C) *Not so important to me* D) *Does not apply*

1) In a published study of health and wellness benefits for patients under Network Care, conducted at the University of California, Irvine Medical College, patients reported an overall improvement in all of the following categories of health and wellness listed below (highlighted in **BOLD**).

How do you hope to benefit from care in this office? (use scale from above to answer each category)

- a) _____ Improvement of my **Physical Symptoms**.
- b) _____ Improvement of **Emotional/Mental Symptoms**.
- c) _____ Improvement of my **Ability to React or Respond to Stress**.
- d) _____ Improvement in **Enjoyment of Life** and the ability to make **Healthier, more Constructive Choices**.
- e) _____ Overall improvement in **Quality of Life**.

2) Is there anything else you may wish to share which may help us to better understand you, your history, or your professional and personal needs which have not been discussed in this profile? (If necessary, please use the back of this form) _____

3) What would motivate you to tell others about the care you receive in this office and encourage others to get under Network Care? _____



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I-5 to Poinsettia lane (South of Palomar Airport Rd, North of La Costa Ave)
West on Poinsettia Lane 1/10th mile.

Left onto Avenida Encinas

After 1st traffic signal on Avenida Encinas, turn left into the next entrance of the Shopping Center. Our building is the **free standing, two story office building** on the south end side of the Poinsettia Village Shopping Center. The address is 7220 Avenida Encinas.

Upon entering the building we are to the left of the water fountain in suite 100.

If you have any questions, please call us at 760.692.0252

