Café of Life Chiropractic

What is your present motivation for consulting our office?

- ☐ **Heal disease, symptoms and infirmities (ill-health)**
- ☐ **Preventing disease, symptoms and infirmities (ill-health)**
- ☐ **Improving family and/or community health**
- ☐ **Maximizing personal health potential**

Vital Information (Adult)

Date _____

First Name _____ **Last Name** _____

Address _____

City _____ **Province**_____ **Postal Code** _____

Email address _____ **Mobile Phone** _____

Home Phone _____ **Business Phone** _____ **ext** _____

Date of Birth: D_____ **/M** _____**/Y** _____ **Age:** _____

Height: _____ **Feet** _____ **Inches** **Weight:** _____ **lbs**

Who is your current employer? _____

Occupation?_____

Marital Status: ○ **Married** ○ **Common Law** ○ **Single** ○ **Widowed** ○ **Divorced**

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

a) I feel helpless, it seems little or nothing works.
b) This feels terrible, 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 I have been experiencing with my body and would like you to assist me in my healing.
e) Anything else? _____

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Name: _____ DOB: _____ Date: _____

Medical History

Name of Medical Doctor: _____MD's phone number: _____

Date and reason for last visit to medical doctor: (symptoms, diagnosis, treatment, outcome)

_____

Do you have any other medical conditions that you are under a doctor's care for?

_____

Please list any medications that you are currently taking (reason & duration)

_____

Please list any medications used in the past for more than three months and their purpose

_____

Please list any procedures or treatments received at a hospital

_____

Family Health

Spouse's Name:_____ Age: _____ Occupation: _____

Spouse's ongoing Health Problems: _____

_____

If deceased, cause: _____ Date: _____

	Age	Health Problems	If deceased, Cause	Age of Death
Mother				
Father				
Brothers & Sisters				
Children				

Have you ever had cancer? ☐ Yes ☐ No What kind?_____ When?_____

Did you have radiation or chemotherapy? ☐ Yes ☐ No Current Status: _____

With any of your medical conditions, have you ever been told not to eat certain foods or vitamins? ☐ Yes ☐ No Please List_____

Do you work with any chemicals? ☐ Yes ☐ No

Do you have any allergies? ☐Yes ☐No What kind? _____

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Health Concerns

Check any of the following symptoms you have experienced in the past 6 months:

- ☐ Low back pain
- ☐ Neck pain
- ☐ Tension/Migraine headaches
- ☐ Tension across top of shoulders
- ☐ Pain between shoulder blades
- ☐ Numbness/tingling in arms/hands
- ☐ Numbness/tingling in legs or feet
- ☐ Anxiety/depression
- ☐ Difficulty with stress
- ☐ Poor mental focus/concentration
- ☐ Low energy/tired/fatigue
- ☐ Weight trouble
- ☐ Nervousness/excessive worry/fear
- ☐ Difficulty sleeping/non restorative sleep
- ☐ Fallen arches (flat feet)
- ☐ Asthma
- ☐ Arthritis
- ☐ High Cholesterol
- ☐ High blood pressure
- ☐ Frequent colds/flus
- ☐ Digestive problems (gas, bloating, heartburn, indigestion)
- ☐ Elimination problems (<2 bowel movements/day)
- ☐ Ringing in ears

What concerns do you have about your health and well being? Please list in order of importance.

_____

_____

Please answer the following questions with respect to your most important concern:

In what part of your body do you experience your concern (symptoms)?

_____

Does your symptom travel to anywhere else in your body? Y ☐ N ☐

If Yes, where? _____

What does this symptom feel like? Please check any that apply:

Sharp ☐ Stabbing ☐ Dull ☐ Achy ☐ Numb ☐ Tingling ☐ Burning ☐

Cold ☐ Pins & Needles ☐ Electricity ☐ Other (specify): _____

When did this symptom begin? _____

What happened? _____

How has this symptom changed over time? Worse ☐ Better ☐ No Change ☐

How often does this symptom occur? _____

When your symptom is present, how long does it last? _____

On the scale below, please mark the level of severity you most consistently feel,

0 = no symptoms **10 = the worst you can imagine**

| _____ |

What makes this symptom better? _____

What makes this symptom worse? _____

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Why do you think you are experiencing this symptom?_____

If you didn't have this symptom what would be different in your life? _____

_____

Are there any other related or associated concerns? _____

Have you ever experienced this symptom or something similar in the past? Y ☐ N ☐

If Yes, please describe _____

Have you sought advice or treatment from a health professional? Y ☐ N ☐

If Yes, what were you told?_____

What was done? _____ **Did it seem to work?** Y ☐ N ☐

Initial Nervous System Profile

Do you have any concerns about your Nerve System and Spine that we should know about?

_____

When was your most recent auto accident? _____

What speed was the collision? _____

Type of impact: Front Impact / Side Impact / Rear Impact

Was treatment received? Please describe _____

When was your most recent strain/stress at work? _____

Please describe the manner of the injury _____

Was treatment received? Please describe _____

Does your job require you remain in long-term stressful postures? _____

(i.e. all day seating, repeated lifting, long-term computer use)

Spinal traumas in the past? _____

Collision, quick burst, or repetitive motion sports: hockey, football, wrestling, basketball, baseball, soccer, tennis, golf, track and field _____

Trauma as a child! i.e. fall on your head, impact to your head, concussion, fall onto your back or tailbone, biking accident _____

_____

Health and Lifestyle

How many hours of sleep do you get? _____ **What is the quality? Low** ☐ **Med** ☐ **High** ☐

Please rate your:	Great	OK	Dissatisfied
Ability to Fall Asleep	☐	☐	☐
Ability to Stay Asleep	☐	☐	☐
Restorative quality of sleep	☐	☐	☐
Ability to Relax	☐	☐	☐
Balance in Life	☐	☐	☐
Alertness and Clarity	☐	☐	☐
Level of Energy	☐	☐	☐

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Are you pregnant or nursing? ☐ Yes ☐ No

Are you trying to get pregnant? ☐ Yes ☐ No

On a scale of 1 (Low) to 10 (High), please rate the following:

Current Life Stress _____ **Level of Health** _____ **Overall Life Happiness** _____

Birth History

Home ☐ **Hospital** ☐ **Forceps or suction** ☐ **Caesarean section** ☐ **Breech** ☐

Drug induced ☐ **Prolonged** ☐ **Other Trauma:** _____

Your Needs and Hopes for Care

In a published study of over 2,800 participants in Network Spinal Analysis, the participants reported an overall improvement in several categories of health and wellness listed below.

Please indicate how you hope to benefit from care in this office:

	Definitely	Would be Nice	Unimportant
Improvement of physical symptoms	☐	☐	☐
Improvement of emotional/mental symptoms	☐	☐	☐
Improvement of my ability to react/respond to stress	☐	☐	☐
Improvement in enjoyment of life/	☐	☐	☐
Ability to make constructive choices	☐	☐	☐
Overall improved quality of life	☐	☐	☐

What is your commitment to yourself, your life and well-being on a scale of 1 to 10, where 1 is no commitment and 10 is "will do whatever it takes"? _____

Are there particular factors or elements about your life, experiences, family, work, recreation, past injuries, genetics, dietary programs, exercises, outlook etc. that you feel may *impair* your opportunity for full vitality and health?

_____

Are there any factors and elements mentioned above that you feel *give you an edge or add* to your health?_____

_____

Is there anything else that may help in understanding you, your history or your professional needs which have not been discussed on this survey?_____

_____

_____

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Finances

Payment in full is expected on all FIRST VISIT services (whether you have insurance coverage or not.) All other fees are to be paid at time of service until other arrangements have been made and agreed upon in writing.

Please indicate your method of payment. ❑ **Cash** ❑ **Debit Card**

First Visit Fees: Comprehensive Exam: $100 X-Rays (if necessary): $30

Doctor's Report (Second Visit): $50 Adjustments/Entrainments: $47