VITAL INFORMATION

Date_____

Name_____ Soc # _____

Address_____ City_____ Zip_____

Date of Birth_____ Age_____ Gender_____ Height_____ Weight _____

Email Address_____

Home Ph_____ Business Ph_____ Cell Ph_____

Employed by_____ Occupation_____

Best number to contact you: (check one)

- ☐ Home
- ☐ Business
- ☐ Cell

Marital Status: (check one)

- ☐ Married
- ☐ Domestic Partner
- ☐ Single
- ☐ Widowed
- ☐ Divorced

Name of Spouse/partner_____ Do you have children? ☐ Y ☐ N

# of children_____ Do they live at home?_____

Reason for seeking services at the Café of Life?

Who can we thank for referring you to us?

Is there anything about your Nerve System and/or Spine we should know about? (previous surgeries)

What is your level of commitment to yourself, your life and well-being?

☐ High ☐ Medium ☐ Low

Additional Comments

LIFE STORY

Please tell us about you. Be as specific as possible.

Name_____ **Date**_____

Briefly describe your nutrition breakfast, lunch and dinner:

Breakfast:
Lunch:
Dinner:
Snacks:

What is your daily fluid intake?

Water:
Other fluid: how much and what

What is your average sleep/rest per day?

What is your quality of sleep? O *good* O *fair* O *poor*

Do you exercise? What do you do and how often?

Type of exercise:
How often?

How are your family relationships? (i.e. good, stressful, none)

What type of work do you do?

Rank your work satisfaction (not satisfied) 1 2 3 4 5 6 7 8 9 10 (very satisfied)

How often do you vacation?

Do you use recreational drugs or over the counter drugs? If yes, please list:

What are your play & relaxation activities?

Any other health related concerns/challenges? Any previous diagnosis?

Name_____ **Date**_____

DO YOU HAVE ANY OF THE FOLLOWING SYMPTOMS? (check all that apply)

☐ Headaches	☐ Allergies	☐ HIV	☐ Shortness of Breath	☐ Neck Pain
☐ High Blood Pressure	☐ Chest Pain	☐ Vertigo	☐ Loss of Smell or Taste	☐ Loss of Balance
☐ Low Back Pain	☐ Dizziness	☐ Anxiety	☐ Stomach Problems	☐ Cancer
☐ Ringing in Ears	☐ Fatigue	☐ Sweats	☐ Heart Condition	☐ Depression
☐ Nervousness	☐ Numbness Arms/Legs	☐ Other _____		

PLEASE TELL US ABOUT YOUR LIFE STRESSORS

C=child T=teenager A=adult N=not at all

1. **PHYSICAL STRESS**					**EXPLAIN**
Birth Trauma (as mother or child)	C	T	A	N	_____
Slips/Falls	C	T	A	N	_____
Car Accidents	C	T	A	N	_____
Sports Injuries	C	T	A	N	_____
Physical Abuse	C	T	A	N	_____
Work Injuries	C	T	A	N	_____
Poor Posture	C	T	A	N	_____
Sitting on your wallet for years	C	T	A	N	_____
Sleeping Position (i.e. stomach, side)	C	T	A	N	_____
Extensive Computer Work	C	T	A	N	_____
Carrying Heavy Purse/Bag/Child	C	T	A	N	_____
Repetitive Lifting/Bending	C	T	A	N	_____
Driving for many hours	C	T	A	N	_____
Continuous Hours Standing/Sitting	C	T	A	N	_____
Bone Fracture/Surgery	C	T	A	N	_____

2. **EMOTIONAL STRESS**					**EXPLAIN**
Relationship	C	T	A	N	_____
Career	C	T	A	N	_____
Children	C	T	A	N	_____
Money	C	T	A	N	_____
Fast Paced Life	C	T	A	N	_____
Holding in Feelings	C	T	A	N	_____
Quick Tempered	C	T	A	N	_____
Verbal Abuse	C	T	A	N	_____
Perfectionist	C	T	A	N	_____
Sickness or Loss of Loved One	C	T	A	N	_____

3. **CHEMICAL STRESS**					**EXPLAIN**
Environment (i.e. pollution)	C	T	A	N	_____
Smoker-Amount	C	T	A	N	_____
Second Hand Smoke	C	T	A	N	_____
Poor Diet	C	T	A	N	_____
Caffeine-Amount	C	T	A	N	_____
Artificial Sweeteners	C	T	A	N	_____
Prescription Drugs	C	T	A	N	_____
Over the counter drug (Advil, Tylenol)	C	T	A	N	_____
Recreational Drugs	C	T	A	N	_____

Name_____ **Date**_____

What do you feel is your primary stress?

What other things have you done to improve your health and well-being?

(circle all that apply)

Massage Acupuncture Yoga Meditation Homeopathy Herbs Run
Supplements Cleanse Consume Organic Foods Pilates Nutritionist
Personal Trainer Physical Therapist Other_____
Chiropractor, Who:_____ Date of Last Adjustment:_____
Frequency of visits:_____ times per week/month
Duration of care:_____ weeks/months/years

For Women Only

Are you pregnant? ☐ no ☐ yes
Are you currently nursing? ☐ no ☐ yes
Are you taking birth control pills? ☐ no ☐ yes
Do you have excessive menstrual flow? ☐ no ☐ yes
Do you experience irregular cycles? ☐ no ☐ yes
Do you experience extreme cramping? ☐ no ☐ yes
Do you have breast implants? ☐ no ☐ yes