

# 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:

<i>Breakfast:</i> <i>Lunch:</i> <i>Dinner:</i> <i>Snacks:</i>
--

What is your daily fluid intake?

<i>Water:</i> <i>Other fluid: how much and what</i>
--

What is your average sleep/rest per day?

<i>What is your quality of sleep?      O good    O fair    O poor</i>
---

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

<i>Type of exercise:</i> <i>How often?</i>
---

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

--

What type of work do you do?

<i>Rank your work satisfaction (not satisfied) 1 2 3 4 5 6 7 8 9 10 (very satisfied)</i>
--

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**

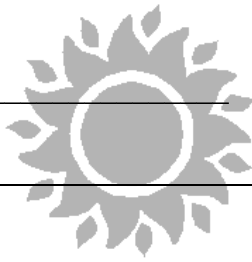
**EXPLAIN**

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