# *Café of Life*

## ***Patient Health History***

Date: _____

Patient No.: _____

Name: _____ Sex: ☐ Female ☐ Male

Address: _____

City: _____ Zip Code:_____ E-Mail _____

H. Phone _____ W. Phone _____ Cell _____

***Do you have a preference as to where we call and can leave a message? (Please Circle.)***

Date of Birth: __/__/__Age: __Employer: _____Occupation: _____
MM DD YR

Spouse's name: _____Names of Children and Ages:_____

Emergency Contact Person_____Phone:_____

Medical Doctor:_____ Phone:_____

Have you ever received chiropractic care? ☐ Yes ☐ No If yes:

Who: _____When: _____ Reason: _____

Referred By: _____

Insured Name _____ Relationship_____DOB____

Insurance Co._____ Phone _____

Address_____

Other Coverage?

Insurance # Group# Coverage ☐ Yes ☐ No

## ***Chief Complaint:*** please describe briefly

_____

How and when did this problem start? _____

Does the pain radiate or travel anywhere else? _____

Is the problem… ☐ constant ☐ intermittent ☐ worse with movement

Is condition worse… ☐ in the A.M. ☐ in the P.M. ☐ no change

Is the condition interfering with your daily life such as…

□ sleep □ work □ routine □ other _____

Is condition getting progressively worse? □ Yes □ No

Pain is… □ sharp □ dull □ throbbing
□ aching □ shooting □ nagging □ other _____

What aggravates your condition / pain? _____

What relieves your condition / pain? _____

If your condition was treated in the past, please describe treatment and results. _____

_____

Have you had x-rays taken of this area? □ Yes □ No

Secondary complaints? _____

***History:*** Have you ever, or do you presently suffer, from any of the following symptoms?

Please list present treatment and include any medications being taken.

□ Headaches □ Ears ring □ Stiff/painful neck □ Nervousness

□ Depression □ Tension □ Fatigue □ Sleep problems

□ Chest Pains □ Heart/lung trouble □ Digestive disorders □ Menstrual problems

□ Numbness/pins & needles in legs □ Numbness/pins & needles in arms □ Cold feet/hands □ Arthritis - where?

Medications: _____

_____

Are there any other medication or treatment you are receiving? (include birth control pills)

_____

_____

List any surgeries and include when? _____

_____

What if any side effects have you experienced from your medications or surgery? _____

_____

## ***Family History:***

| | Heart Disease | Stroke | Cancer | Arthritis | Diabetes | Other |
|---|---|---|---|---|---|---|
| Mother's Side | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ _____ |
| Father's Side | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ _____ |

## ***Events & Habits:*** Many health problems have roots in early spinal subluxations and nerve interference.

| Yes | No | | Patient's Comments |
|---|---|---|---|
| | | 1. PREGNANCY: Did your mother…. | |
| ☐ | ☐ | Experience any falls /injuries during pregnancy? | _____ |
| ☐ | ☐ | Exercise throughout the pregnancy? | _____ |
| ☐ | ☐ | Maintain a proper diet? | _____ |
| ☐ | ☐ | Experience any prolonged illness? | _____ |
| | | 2. BIRTH PROCESS | |
| ☐ | ☐ | Was it a vaginal birth? | _____ |
| ☐ | ☐ | Was the delivery long? | _____ |
| ☐ | ☐ | Was the delivery difficult? | _____ |
| ☐ | ☐ | Were forceps used? | _____ |
| | | 3. GROWING YEARS | |
| ☐ | ☐ | Were you breast fed? | _____ |
| ☐ | ☐ | Were you taught how to care for your spine? | _____ |
| ☐ | ☐ | Any notable falls? | _____ |
| ☐ | ☐ | Any significant childhood injuries or illnesses? | _____ |
| ☐ | ☐ | Any childhood surgeries or prolonged medications? | _____ |
| ☐ | ☐ | Mental or physical abuse? | _____ |
| | | 4. ADULTHOOD | |
| ☐ | ☐ | Ever in a motor vehicle accident? | _____ |
| ☐ | ☐ | Any notable falls or injuries as an adult? | _____ |
| ☐ | ☐ | Hobby or sports injuries? | _____ |
| ☐ | ☐ | Taught proper body movement and lifting procedures | _____ |
| ☐ | ☐ | Smoke? | _____ |
| ☐ | ☐ | Drink alcohol? | _____ |
| | | ☐ Daily ☐ Weekends ☐ Sporadically | _____ |
| ☐ | ☐ | Exercise regularly? | _____ |
| | | ☐ Daily ☐ Weekends ☐ Sporadically | _____ |
| ☐ | ☐ | Proper posture? | _____ |
| ☐ | ☐ | Eat as healthy as you think you should? | _____ |
| ☐ | ☐ | Are you or have ever been overweight? | _____ |
| ☐ | ☐ | Stress? Occupational/Physical/Mental | _____ |
| ☐ | ☐ | Other traumas or problems? | _____ |
| | | Sleep posture - ☐ side ☐ back ☐ stomach | _____ |
| | | Sleep surface - ☐ mattress ☐ water bed | _____ |
| | | Approximate age of bed _____ | _____ |

## ***About Your Health:***

When a patient seeks chiropractic care, and when a chiropractor accepts a patient for such care, it is essential that both are seeking and working for the same goals.

Chiropractic does NOT diagnose or treat disease. Chiropractic has one goal to locate, assess, and reduce spinal interference to the nerve system.

The purpose of the nerve system is to transfer vital information for all human works from bodily function to emotions, creativity, performance, and spiritual expression. Interference to this master system automatically produces improper communication, a lack of ease, and potential mal-function within the body.

The SUBLUXATION (spinal misalignment producing nerve interference) is a detriment to life, healing, and health. Correction of the subluxation through a specific chiropractic adjustment allows the body to release nerve interference and LIFE FORCE ENERGY This allows the INNATE healing power of the body to work at its maximum efficiency and potential in order to restore, maintain, and promote healing & health naturally.

CHIROPRACTIC IS NOT A SUBSTITUTE, AN ALTERNATIVE, OR PREVENTATIVE FORM OF MEDICINE.

WE DO NOT DIAGNOSE, TREAT, OR CURE CONDITION(S) OR DISEASE(S).

CHIROPRACTIC SPECIALIZES IN THE EXPRESSION OF LIFE FORCE ENERGY, HEALING, VITALITY & WELLNESS.

IF WHILE BEING SERVED CHIROPRACTIC CARE, YOU DO BECOME CONCERNED ABOUT SYMPTOMS OR CONDITIONS, WE SUGGEST YOU SEEK THE HELP OF A SICKNESS AND DISEASE CARE PROFESSIONAL.

I, _____, having read the above statement, and understanding it fully, do undertake chiropractic care on this basis.

I authorize the staff to perform any necessary services needed for assessment and reduction of subluxations.

I guarantee this form was completed correctly and to the best of my knowledge.

I understand it is my responsibility to inform the office of any changes to my personal contact information, insurance, or medical/health status.

Patient's Signature: _____Date____/____/____
Adult Patient / Parent or Guardian / Spouse