



CHIROPRACTIC CENTER

1014 Piedmont Ave Atlanta GA 30309 404.876.0550 www.cafeoflifeatlanta.com

Vital Information

Date _____

Name _____ Soc. # _____

Address _____ City _____ Zip _____

Email Address _____ Date of Birth _____

Home Ph _____ Business Ph _____ Cell ph _____

Please indicate the best number to contact you _____ Home _____ Business _____ Cell

Marital Status: _____ Married _____ Domestic Partner _____ Single _____ Widowed _____ Divorced

Name of Spouse/partner _____ Do you have children? Y / N

of children _____ Children living at home? Y / N

Reason for seeking services at the Café of Life?

How were you referred to the Café of Life?

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

What is your level of commitment to yourself, your life and wellbeing?

_____ High _____ Medium _____ Low

Additional comments:

Life Style History

Briefly describe your nutrition breakfast, lunch and dinner:

What is your daily fluid intake?

What is your average sleep & rest per day?

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

Family relationship (i.e. good, stressful, none)

Rank your satisfaction with work. Low 1 2 3 4 5 6 7 8 9 10 High. What type of work do you do?

How often do you vacation?

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

What are your play & relaxation activities?

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

DO YOU HAVE ANY OF THE FOLLOWING HEALTH CHALLENGES OR SYMPTOMS?

Headaches	Allergies	HIV	Shortness of Breath	Neck Pain
High Blood Pressure	Chest Pain	Vertigo	Loss of Smell or Taste	Cold sweats
Low Back Pain	Dizziness	Anxiety	Stomach Problems	Cancer
Ringing in Ears	Fatigue	Hot Flashes	Heart Condition	Constipation
Depression/Nervousness	Fainting	Ulcers	Problem Urinating	Mood swings
Cold hands/feet	Diarrhea	Depression	Heart Burn	Irritability
Difficulty Sleeping	Numbness/tingling in Arms/Legs		Menstrual Irregularity/pain	

Name _____

The following three areas of stress can cause a misaligned vertebra (subluxation). Do you recognize any of these stresses? **C=child T=teenager A=adult or N=not at all**

1. Physical Stress:

EXPLAIN

Birth Traumas (as a mother or a 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/Book 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:

Relationships	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	_____
Hold in Feelings	C	T	A	N	_____
Quick Tempered	C	T	A	N	_____
Verbal Abuse	C	T	A	N	_____
Perfectionist	C	T	A	N	_____
Procrastinator	C	T	A	N	_____
Sickness or Loss of Loved One	C	T	A	N	_____

3. Chemical Stress:

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 drugs (i.e.: Advil: Tylenol: Aspirin)	C	T	A	N	_____
Recreational Drugs	C	T	A	N	_____

What do you feel is your primary stress?

Welcome to the Café of Life!

Thank you for choosing the Café of Life for your chiropractic care. *We are committed to serve you an exceptional chiropractic experience!* At the Café of Life you will receive the highest quality of chiropractic care available, so that you can enjoy an active and healthy life.

If you ever have any questions, please don't hesitate to ask! All of your questions, even the ones you haven't thought of yet, will be answered during your second visit and your Human Potential Program.

We look forward to a long, healthy relationship with you.

Terms of Acceptance

The practice of chiropractic at the Café of life consists of:

1. Analysis of the spine for the purpose of locating vertebral subluxations (spinal misalignments causing nerve interference).
2. Adjustment of the spine for the purpose of correcting vertebral subluxations.
3. Education and encouragement of our people to become aware of and responsible to their well-being.
4. Empowerment of our people as to the inherent healing capabilities of the human body.

Our intention is to provide you with the best care we can offer as outlined above. We do not offer care with the intent of "treating" or "curing" diseases or conditions.

I, _____, have read and understand the above statement and I hereby give permission for Dr. Chris Alberts to continue with my child's and/or my initial consultation and assessment. I also agree to return at a later date to attend an orientation and allow Dr. Alberts to report his findings and recommendations to me immediately following the orientation. By agreeing to this, I am in no way obligated to follow the advice given to me in the orientation and report of findings.

Signed: _____

Name (*Please Print*): _____

Witness: _____

Date: ____/____/____