café of life

"Serving Life… Want Some?"

What to Expect

Welcome to Café of Life! Our first step towards helping you move towards greater health and vitality is to find out more about you. Please fill out the following information regarding your health, your life and your overall wellbeing. Chiropractic care focuses on you as a whole person, not only on your specific problems. All our life's experiences make us who we are today, so the more information you can provide us, the better we will be able to serve you.

After the initial consultation, a chiropractic assessment will thoroughly evaluate your spine and nervous system to determine your need for care. After the doctor reviews and studies your results, your next visit will share the findings of this assessment and explain our Recommendations and Action Plan to optimize your health and to allow you to live life more fully!

Part of our commitment to is to provide as much information as possible about health, healing and well being. Each new person who begins care is encouraged to attend one ***chiropractic orientation night***. It is included in the price of your first visit and will greatly enhance your experience, as well as help you get the most value for your investment. Please bring your partner or a friend to help support you in your health goals! It is held right here in our office at convenient times during the week.

Our mission to serve every human being with love, honour and respect. We provide life-enhancing chiropractic care to all ages in an environment which encourages people to commit to their continued well being and empowers them to maximize their human potential.

Once again, welcome to the Café of Life! We look forward to helping you and your family to achieve outrageous health and vitality. We are honoured to serve you!

Health History

Name ______________________________ Date ______________

Address ______________________ City/Town __________ Postal Code ________

E-mail Address ____

Would you like to receive our "Living Healthy" e-newsletter? ○ Yes ○ No

Date of Birth ______m/______d/______y/ Gender ○ Male ○ Female

Home Ph ______________ Business Ph ______________ Cell Ph ______________

Current employer ____________________ Occupation ____________________

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

Name of Spouse/Partner ____________________ Do you have children? ○ Yes ○ No

Names/ages of children ____

Are you pregnant? ○ Yes ○ No weeks ________ Height __________ Weight __________

Whom may we thank for referring you to the Café of Life? ____________________

Check the phrase that most represents your reason for care:

○ Wellness ○ Prevention ○ Feel good ○ Symptom Relief

<u>Health Concerns</u>

Please list heath concerns according to their severity:

Concern	Rate of Severity 1=mild, 10=worst	When did it start? For how long?	If you had the condition before, when?	Did the problem begin with an injury?	What % of time is pain present?
1.					
2.					
3.					
4.					

Do you have a family history of this or similar symptoms? ○ Yes ○ No
Please explain:____

____

What have you done for this condition? Was it of benefit? ____________________

____

Is this condition interfering with your:
○ Work ○ Sleep ○ Daily Routine ○ Sports/Activities ○ Other____________________
What aggravates your condition?____

Name of Primary Health Care Provider: ____

What other Doctor's have you seen for this condition?
○ Chiropractor ○ Medical Doctor ○ Dentist ○ Other ______________________

1. Name/Address: ____
   When: ________________ What did they say was wrong? _________________________
   What did they do? ____

2. Name/Address: ____
   When: ________________ What did they say was wrong? _________________________
   What did they do? ____

Did you see a:

- ○ Symptom Based Chiropractor (focuses only on neck and back pain)
- ○ Wellness Chiropractor (focuses on health and well being as the underlying cause of pain)

Have you made any changes in your life due to this pain, illness, condition, etc?
(i.e., eat better, less alcohol or drugs, meditate or breathe more, less destructive sports, activities etc.) ____

____

If you "get better" or get rid of this condition will you go back to your "old ways'? ○ Yes ○ No

Are you unable to do certain activities that you would like to do because of this pain, illness, condition? (i.e. sports, walk, pick up children or grandchildren, etc.)

____

____

What lesson(s) have you learned from your healing process to date?

____

Physical Health

Please list all surgeries you have had:

1. Type ______________________________ When __________ Doctor ______________
2. Type ______________________________ When __________ Doctor ______________
3. Type ______________________________ When __________ Doctor ______________
4. Type ______________________________ When __________ Doctor ______________

Please list any accidents and/or injuries: auto, work related, sports, or other (Especially those related to your present problems).

1. Type________________________ When____________ Hospitalized? ○ Yes ○ No
2. Type________________________ When____________ Hospitalized? ○ Yes ○ No
3. Type________________________ When____________ Hospitalized? ○ Yes ○ No

Have you ever had x-rays taken? ○ Yes ○ No When?__________ Where?____________
What area of your body:____

Mark the following conditions you have had in the **PAST** with a "**P"** and have **CURRENTLY** with a "**C"**

○ Allergies ○ Asthma ○ Sinus Problems ○ Eczema ○ Pneumonia ○ Emphysema

○ Diarrhea ○ Constipation ○ Heartburn ○ Ulcers ○ Low Blood Sugar ○ Gall Bladder Problems

○ Measles ○ Rheumatic Fever ○ Mumps ○ Whooping Cough ○ Polio ○ Tuberculosis

○ Miscarriage ○ Multiple Sclerosis ○ HIV (AIDS) ○ Convulsions ○ Epilepsy ○ Ringing in ears

○ Arthritis ○ Back Pain ○ Neck Pain ○ Migraines ○ Headaches ○ Malaria

○ Heart Attack ○ Arteriosclerosis ○ Heart Disease ○ High Blood Pressure ○ Stroke

○ Depression ○ Anxiety ○ Gout ○ Alcoholism ○ Thyroid Problems ○ Anemia

○ Irregular Periods ○ Menstrual Cramps/PMS ○ Diabetes ○ Cancer ○ Cold Sores

Other (please explain)

____

____

How do you grade your physical health?

○ Excellent ○ Good ○ Fair ○ Poor ○ Getting better ○ Getting worse

Compared to 5 years ago, are you now: ○ Not As Healthy ○ As Healthy ○ Healthier

What strategies have you used?

____

5 years from now will you be: ○ Not As Healthy ○ As Healthy ○ Healthier

What additional strategies will you have to use to get different results?

____

Biochemical Health

Current Medications:

Please list ALL drugs you currently take or have taken in the past 6 months:

Name ______________________________ Dosage _______ For what? ______________

Name ______________________________ Dosage _______ For what? ______________

Name ______________________________ Dosage _______ For what? ______________

Name ______________________________ Dosage _______ For what? ______________

Name ______________________________ Dosage _______ For what? ______________

Name ______________________________ Dosage _______ For what? ______________

Please list all nutritional supplements, vitamins, homeopathic remedies you presently take:

Name ____________________________________ For what? ________________

Name ____________________________________ For what? ________________

Name ____________________________________ For what? ________________

Name ____________________________________ For what? ________________

Name ____________________________________ For what? ________________

Diet:

Please circle any dietary selection that is appropriate for you, and grade according to the following scale:

Daily:
D - Consume this daily
FD - Consume this a few times per day

Weekly:
W - Consume this weekly
FW - Consume this a few times per week

Monthly:
M - Consume this monthly
FM - Consume a few times per month

Never:
O - Do not consume this

Alcohol ________	Eggs________	Fasting ________	Fruit ________
Tobacco________	Fish ________	Diet Food ________	Organic Foods ________
Coffee ________	Beef ________	Weight Control Diet ______	Raw Vegetables ________
Pop ________	Poultry ________	Artificial Sweetener ______	Whole Grains ________
Fried Foods _______	Seafood ______		Cooked vegetables ______
Refined Sugar _____	Dairy ________		Canned vegetables_______

The type of diet I usually follow is classified as:

____

Psychological and Emotional Health

With each of the following stress situations, please write either **"P"** for **PAST** or **"C"** for **CURRENT**:

	Mild	Moderate	Severe		Mild	Moderate	Severe
Childhood stress	_____	_____	_____	Work related stress	_____	_____	_____
School stress	_____	_____	_____	Stress of commuting	_____	_____	_____
Play or recreational	_____	_____	_____	Loss of loved one	_____	_____	_____
Family stress	_____	_____	_____	Change in lifestyle	_____	_____	_____
Personal relationship	_____	_____	_____	Change in vocation	_____	_____	_____
Stress of being sick	_____	_____	_____	Abuse	_____	_____	_____

How do you grade your emotional/mental health?

○ Excellent ○ Good ○ Fair ○ Poor ○ Getting better ○ Getting worse

Changes and Commitments

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

○ High ○ Medium ○ Low

Is your present lifestyle choices moving you: ○ Towards Health ○ Away From Health

Are you interested in finding the cause of your health problems, rather than covering up the effects?

○ Yes ○ No

Are you interested in knowing more about how your nutrition (food you eat) affects your overall health and wellbeing?

○ Yes ○ No ○ Maybe

If dietary changes are indicated, would you be willing to make changes in your diet?

○ Yes ○ No ○ Maybe

Would you take whole food supplements if indicated?

○ Yes ○ No ○ Maybe

In addition to the main reason for your visit today, what additional health goals do you have for your future?

____

____

Is there anything else that you would like to tell us, to help us understand you and your health concerns?

____

____

____

____

Informed Consent to Chiropractic Care

When a person seeks chiropractic care, it is essential for both the individual and the chiropractor to be working towards the same objective.

Chiropractic care has one goal, to correct vertebral subluxations. It is important that each person understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of the nerve function and interference to the transmission of mental impulses, resulting in a decrease in the body's innate ability to express its maximum health potential.

Adjustment: An adjustment is a specific application of forces to facilitate the body's correction of a vertebral subluxation. Our method of correction is by specific adjustments of the neurospinal system.

Health: A state of optimal physical, mental, and social wellbeing, not merely the absence of symptoms.

I understand that my care at the Café of Life will be focused on the detection and correction of vertebral subluxations. I hereby request and consent to the performance of chiropractic adjustments and assessments. Understanding that every body has a different potential for wellness thus, the maximal results I will receive in this office cannot be predicted or guaranteed.

Chiropractic care is considered to be one of the safest and most effective forms of care. I understand and am informed that, unlike many other health care professions, the risks associated in receiving chiropractic care are extremely minimal. In recent years there have been rare incidents of injury to the vertebral artery during the course of care by medical doctors, physiotherapists and chiropractors. To put this in perspective, the risk of stroke in the general population is 0.00057%. The risk of stroke after a chiropractic adjustment is 0.00025%. The risk of death from taking an aspirin and/or other anti-inflammatory drugs is 0.04%.

It is not our goal or intention to diagnose, treat or attempt to cure any physical, mental, emotional symptoms. Our expertise is in health, wellness, healing and human physiology. However, if during the course of chiropractic care, we encounter unusual findings, we will bring these to your attention. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area. Please discuss care alternatives with attending chiropractor.

Our primary goal is to release life in the body, through the detection and correction of vertebral subluxations.

At the Café of Life, the privacy of your personal information is an essential part of our office providing you with quality care. We are committed to collecting, using and disclosing your personal information responsibly. Our office has a privacy policy that complies with federal law, which you may view at any time by asking our staff.

SIGNATURE REQUIRED ON BACK →

I, ________________________ have read and fully understand the above statements.
(PRINT NAME)

I have also had an opportunity to ask questions about its content. I therefore accept chiropractic assessments and care on this basis. I intend this consent form to cover the entire course of my care in this office with Dr. Sebastian Hoffsuemmer or other attending chiropractor.

____

(SIGNATURE) (DATE) (WITNESS)

Consent to assess and adjust a minor:

I, _____________________________________, being the parent or legal guardian of
(PARENT/GUARDIAN NAME)

_______________________________________ have read and fully understand the above terms of

(CHILD'S NAME)

acceptance and hereby grant permission for my child to receive chiropractic care.

(Information released from: The National Center for Health Statistics USA, 1993 and A Risk Assessment for Cervical Manipulation vs. Non-Steroid Anti-inflammatory Drugs for the Treatment of Neck Pain, JMPT, Oct. 1995)