

Vital Information



Date _____

Name _____

Parent(s) Names _____

Siblings' Names and Ages _____

Address _____ City/Town _____ Postal Code _____

Parents' 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 _____

Whom may we thank for referring your child to the Café of Life? _____

Check the phrase that most represents your child's reason for care:

Wellness Prevention Feel good Symptom Relief

Reason for your child seeking services at the Café of Life: _____

Has your child ever seen a Chiropractor? If yes, who? Date of last visit: _____

Name of Primary Health Care Provider _____

Date of last visit _____ Purpose of visit _____

Health Concerns

Please list your child's health 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 your child's condition? Was it of benefit?

Physical Health

Please list all surgeries your child has had:

1. Type _____ When _____ Doctor _____
2. Type _____ When _____ Doctor _____

Please list any accidents and/or injuries: auto, sports, or other (Especially those related to your child's 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 child's body: _____

Mark the following conditions your child has had in the **PAST** with a "**P**" and has **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)

Biochemical Health

CURRENT MEDICATIONS

Please list ALL drugs your child currently takes or has taken in the past 6 months:

- Name _____ Dosage _____ For what? _____
Name _____ Dosage _____ For what? _____
Name _____ Dosage _____ For what? _____

Please list all nutritional supplements, vitamins, homeopathic remedies your child presently takes:

- Name _____ For what? _____
Name _____ For what? _____

DIET

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

Daily:

D - Consume this daily

FD - Consume this a few times per day

Monthly:

M - Consume this monthly

FM - Consume a few times per month

Weekly:

W - Consume this weekly

FW - Consume this a few times per week

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 your child usually follows is classified as:

Pregnancy and Birth History

PREGNANCY

Trauma/ illness during pregnancy _____

During the pregnancy did the mother:

Smoke? Yes No How much? _____

Drink? Yes No How much? _____

Were any supplements taken during the pregnancy? Yes No _____

Were any drugs taken during the pregnancy? Yes No _____

Any ultrasounds or other radiation? Yes No

How many and for what reasons? _____

LABOUR

Was labour induced? Yes No Duration of labour? _____

Did mother receive drugs? Yes No

BIRTH

Type of birth? Cephalic (head first) Breech (feet first)

Location of birth? Home Hospital Birthing center

Birth Assistants? Midwife Doula Medical Doctor

Was there any assistance needed during birth?

Forceps Cesarean Vacuum extraction

Were there complications during birth? Yes No

Please explain: _____

Was there any evidence of birth trauma to the infant? Check all that apply:

- Bruising Odd shaped head
 Stuck in birth canal Fast or excessively long birth
 Respiratory depression Cord around neck

Was your child subjected to any of the following? Check all that apply:

- Silver nitrate drops in eyes Incubation - How long? _____
 Vitamin K shot Separation from you - How long? _____
 Hepatitis shot

Childhood History

VACCINATION HISTORY

What vaccinations were given and at what age?

Were there any negative reactions? Yes No _____

Reason for vaccinations _____

GROWTH AND DEVELOPMENT

Any falls from couches, beds, change tables? Yes No _____

Any traumas resulting in bruises, fractures, stitches? Yes No _____

Any hospitalizations or surgeries? Yes No _____

History of antibiotics? Yes No _____

Night terrors, sleep walking, difficulty sleeping Yes No _____

Was child breast fed? Yes No For how long? _____

Do you consider their sleeping pattern normal? Yes No _____

Quality of Sleep Good Fair Poor Number of hours _____

Food/juice intolerance? _____

Behavior problems? Yes No _____

Do you feel that your child's social and emotional development is normal for their age?

Yes No

Any sports played? Yes No _____

Is school backpack used?

Yes No

Heavy Light

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 or Kara 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)