

Dr. April E. Warhola  
Chiropractor  
404.917.4992



Café of Life  
318 Cherokee Ave, Unit 105  
Atlanta, GA 30312

## Vital Information

Date:

Name \_\_\_\_\_ Soc # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Gender \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Home Phone \_\_\_\_\_

Email Address \_\_\_\_\_ Best number to contact you:

Cell/Business/Home (circle one)

Employed By \_\_\_\_\_ Occupation \_\_\_\_\_

Marital Status: Married ~ Domestic Partner ~ Single ~ Widowed ~ Divorced (circle one)

Name of Spouse/Partner \_\_\_\_\_ Do you have children? Y/N

# of Children \_\_\_\_\_ Do they live at home? \_\_\_\_\_

Please write your answers to the following:

What is your reason for seeking services at the Café of Life?

Who can we thank for referring you to us?

Is there anything about your Nervous System and/or Spine that we should know about?

Additional Comments:

# Life Story

Name \_\_\_\_\_ Date \_\_\_\_\_

Please describe an average meal in your day:

Breakfast:

Lunch:

Dinner:

Snacks:

What is your daily fluid intake? (what and how much) \_\_\_\_\_

What is your average sleep/rest per day?

What is your quality of sleep? good fair poor

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

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

What type of work do you do?

How often do you vacation?

What are your play and relaxation activities? \_\_\_\_\_

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

Name \_\_\_\_\_ Date \_\_\_\_\_

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

## 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
- Nervousness
- Fatigue
- Sweats
- Heart Condition
- Depression
- Numbness in Arms/Legs
- Other \_\_\_\_\_

## Please Tell Us About Your Life Stressors

The following areas of stress can cause misaligned vertebra (subluxation). Do you recognize any of these stresses either presently or in the past?

<u>Physical Stress</u>	<u>Past/Present</u>	<u>Please Explain</u>
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Birth Trauma (Mother or Child)

Physical Abuse

Slips/Falls

Work Injuries

Poor Posture

Sitting on your Wallet

Sleeping Position

Extensive Computer Work

Carrying Heavy Purse/Bag/Child

Repetitive Lifting/Bending

Driving for Long Periods of Time

Sitting/Standing for Long Hours

Bone Fracture/Surgery

Emotional Stress

Relationships

Career

Children

Money

Busy Lifestyle

Quick Tempered

Verbal Abuse

Hold in Feelings

Perfectionist

Depression/Nervousness

Sickness or Loss of Loved One

Chemical Stress

Smoker (amount)

Second Hand Smoke

Poor Diet

Caffeine (amount)

Artificial Sweeteners

Prescription Drugs

Over-the-Counter drugs

Recreational Drugs

Environmental Pollution

What do you feel is your primary stress?

What other things have you done to improve your health and well-being? (yoga, trainer, herbs, massage, etc)

Have you had previous Chiropractic Care? Who? \_\_\_\_\_

Date of last adjustment:

How long were you under care?

What is your level of commitment to yourself, your life and well-being?

High                  Medium                  Low

### **For Women Only**

Are you pregnant?	YES/NO
Are you currently nursing?	YES/NO
Are you taking birth control pills?	YES/NO
Do you have excessive menstrual flow?	YES/NO
Do you experience irregular cycles?	YES/NO
Do you experience extreme cramping?	YES/NO
Do you have breast implants?	YES/NO

Please Sign and Date: \_\_\_\_\_