FILE #: _____

CAFE OF LIFE
CHIROPRACTIC

101 COLLIER STREET | BARRIE, ON | 705.792.9226 | reservations@cafeoflifebarrie.com

Welcome to Café of Life! Our first step towards helping you move towards greater health and vitality is to find out more about you. We require you to fill out the following information because chiropractic care focuses on you as a whole, including your health, your life and your overall well-being

What to expect on your FIRST VISIT:

THE CONSULTATION:

The consultation gives us a chance to sit down with you and have a conversation about your health concerns (if you have any), health history, and future health goals. Here you will learn a bit about what we do and don't do.
If there is an indication that any concerns you have may be linked to the functioning of your spine and nervous system, then we can continue with the exam.

THE EXAMINATION

The purpose of the examination is threefold:

1. To assess the current state of your spine and nervous system.
2. Determine if there are any malfunctions of the spine that are directly affecting your level of health.
3. Learn what level of care (including frequency) is necessary to help you reach your goals.

The examination consists of an assessment, before the first adjustment:

Heart Rate Variability
This test measures your overall health and adaptability. The more adaptable you are, the faster you will heal.

Hands on Spine Palpation.
After your consultation and HRV scan, the doctor will be checking your posture and physically examining your spine to locate any areas of malfunction.

If, during the exam, there is no indication that further testing is required (for example, x-rays or other imaging), we will proceed with the first adjustment.

What to expect on your SECOND VISIT:

On your second visit we will go over any questions you may have, and a care plan personalized to you based on your exam results and health goals.

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BASIC INFORMATION

Name _____ Date _____

Address _____

City/Town _____ Postal Code _____

E-mail Address _____

Home Ph _____ Business Ph _____ Cell Ph _____

Date of Birth _____d/_____m/_____y/ **Gender** ○ Male ○ Female ○ Other

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 _____

How did you hear about us? _____

Current patient's name (if applicable) _____

Indicate the phrase that most represents your reason for care:

☐ Wellness ☐ Prevention ☐ Feel Good ☐ Symptom Relief

If you have no specific symptoms or complaints, and are here mainly for wellness services, please check (√) here ☐ and skip to 'The Beginning Years' section.

HEALTH CONCERNS

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 the time is the pain present?
1.					
2.					
3.					
4.					

Do you have a family history of this or similar symptoms? ☐ Yes ☐ No

Please explain: _____

_____

What makes these problems worse? _____

What makes these problems better? _____

Is this condition interfering with your:

☐ Work ☐ Sleep ☐ Daily Routine ☐ Sports/Activities ☐ Other _____

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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, etc.) _____

Have you made any changes in your life due to this pain, illness, condition, etc? (i.e: eating better, consuming less alcohol or drugs, meditating or breathing more, participating in less destructive sports and activities, etc.) _____

_____

Have you seen anyone else for this condition? _ _____

☐ Chiropractor ☐ Medical Doctor ☐ Physiotherapist ☐ Other_____

Was it helpful?_____

Have your ever seen a chiropractor before? If so, were they 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)

BEGINNING YEARS

Is there anything about your childhood years that you want us to know?

_____

_____

_____

_____

_____

_____

THE ADULT YEARS (18-YEARS TO PRESENT) Tell us more about your stressors in your adult life.

Do / did you smoke? ☐ Yes ☐ No

Do / did you drink alcohol? ☐ Yes ☐ No

Have you been in any accidents? ☐ Yes ☐ No

If so, was your nervous system checked by a chiropractor afterwards?

Have you had any surgeries? ☐ Yes ☐ No For what?_____

Do/Did you participate in extreme sports? ☐ Yes ☐ No

Do/Did you play contact sports? ☐ Yes ☐ No

If so, did you have your spine and nervous system checked regularly by a chiropractor? ☐ Yes ☐ No

On a scale of 1-10 rate your stress level (1-none, 10-severe)

Occupational Stress_____ Personal Stress_____

List all medications you are taking:_____

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Have any of the following conditions affected you *chronically* (in the past and/or present)?

☐ Allergies	☐ Asthma	☐ Sinus Problems	☐ Eczema	☐ Frequent Colds	☐ Confusion
☐ Diarrhea	☐ Constipation	☐ Gall Bladder Problems	☐ Heartburn	☐ Ulcers	☐ Low Blood Sugar
☐ Frequent Nausea	☐ Chronic Infections	☐ Osteoporosis	☐ Balance Problems	☐ Bladder Trouble	☐ Diabetes
☐ Sexual Dysfunction	☐ Forgetfulness	☐ Thyroid Problems	☐ Ringing in ears	☐ Multiple Sclerosis	☐ Dizziness
☐ Shortness of Breath	☐ Miscarriage	☐ Loss of Sleep	☐ Migraines	☐ Headaches	☐ Malaria
☐ Heart/Vascular Problems	☐ Arthritis	☐ Fatigue	☐ Anemia	☐ Stroke	☐ Anxiety
☐ High Blood Pressure	☐ Menstrual Cramps/PMS	☐ Irregular Periods	☐ Mood Swings	☐ Depression	☐ Alcoholism
☐ Cancer of					

Other (please explain)_____

_____

How would 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

5 years from now, will you be: ☐ Not as Healthy ☐ As Healthy ☐ Healthier

How would 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

Are 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 ☐ 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?

_____

_____

_____

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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 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. I understand 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 with 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.

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.

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 (under 18):

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

_____ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.
(CHILD'S NAME)