cafe of life
CHIROPRACTIC STUDIO

Adult New Patient Application

Date: _____ (Day) _____ (Month) _____ (Year)

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss. ☐ Dr. Name: _____ ☐ Male ☐ Female

Birth Date (DD/MM/YYYY): _____ How do you wish to be addressed in our office? _____

Address: _____ City: _____ Province: _____ Postal Code: _____

Mobile Phone: ( )_____ Home Phone: ( )_____ Work Phone: ( )_____

Email Address: _____ ☐ Subscribe me to your Monthly Newsletter

Occupation: _____ Hobbies: _____

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Partner's Name: _____

Children's Names & Ages: _____

Health Profile

Do you have any persistent health challenges? Please describe. _____

_____

Please mark an "X" where you believe your health is and an "O" where you would like to be.

☐ 0-59 Very Challenged → ☐ 60-69 Challenged → ☐ 70-79 Transition → ☐ 80-89 Good → ☐ 90-100 Excellent

Previous Chiropractor: _____ Last Visit: _____

Briefly describe your previous chiropractic experience: _____

How did you hear about our office? _____

I authorize the Cafe of Life Chiropractic Studio and team to perform a comprehensive examination of my spine and nervous system if necessary.

Name: _____ Witness Name: _____

Signature: _____ Witness Signature: _____

Date (DD/MM/YYYY): _____ Date (DD/MM/YYYY): _____

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Name: _____ Date: _____ / _____ / _____
Day Month Year

What have you tried that has helped improve your condition? _____

What have you tried that has NOT helped? _____

Is this condition interfering with your: ☐ Sleep ☐ Work ☐ Hobbies ☐ Exercise ☐ Sports ☐ Mental State

What other health professionals have you seen for this condition? _____

What was the course of action recommended? _____

If you have no specific health challenges and are here to become healthier and more well, check here: ☐

Have you ever injured your spine and nervous system? ☐ Yes ☐ No If yes, please describe: _____

General Health Profile

Please check all symptoms and conditions even if they do not seem related to your primary reason for consulting our practice:

- ☐ Neck pain
- ☐ Headaches
- ☐ Pins and needles in arms
- ☐ Numbness in fingers
- ☐ Lights bother eyes
- ☐ Dizziness
- ☐ Fainting
- ☐ Loss of concentration
- ☐ Buzzing in ears
- ☐ Sleeping problems
- ☐ Nervousness
- ☐ Low back pain
- ☐ Pins and needles in legs
- ☐ Shoulder pain
- ☐ Midback pain
- ☐ Chest pain
- ☐ Heartburn
- ☐ Difficulty breathing
- ☐ Constipation
- ☐ Cold hands
- ☐ Cold feet
- ☐ Allergies
- ☐ Loss of smell
- ☐ Numbness in toes
- ☐ Loss of balance
- ☐ Urinary problem
- ☐ Foot trouble
- ☐ Stomach upset
- ☐ Depression
- ☐ Diarrhea
- ☐ Skin conditions
- ☐ Loss of taste
- ☐ Sinus trouble
- ☐ Fatigue
- ☐ Cold sweats
- ☐ Hot flashes
- ☐ Earaches
- ☐ Irritability
- ☐ Mood swings

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Name: _____ Date: _____ / _____ / _____
Day Month Year

Family Health Profile

Please list any health conditions or concerns that your immediate family may have:

Grandparents: _____

Mother: _____

Father: _____

Siblings: _____

Spouse / Partner: _____

Children: _____

Other: _____

What Do YOU Want?

If our doctors were meeting with you ONE YEAR from today and you were looking back over the past year, what has to have happened during that period for you to be happy with the progress you've made with your health?

_____

_____

What are the 3 biggest challenges holding you back from achieving the level of health you truly want?

1. _____

2. _____

3. _____

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Name: _____ Date: _____ / _____ / _____
Day Month Year

Circle 'Yes' if the answer applies and explain in more detail as necessary.

Physical Stress

Explanation

1. Forceps, suction, extraction, or caesarean delivery — Details : _____
2. Accidents (auto, work related, falls or other) — ☐ Yes : _____
3. Surgical operations — ☐ Yes : _____
4. Strains, sprains and/or broken bones — ☐ Yes : _____
5. Poor posture (excessive computer work, driving) — ☐ Yes : _____
6. Poor sleeping habits — ☐ Yes : _____
7. Repetitive movements — ☐ Yes : _____
8. Sports injuries — ☐ Yes : _____
9. Heavy lifting and/or bending — ☐ Yes : _____
10. Overweight — ☐ Yes : _____
11. Lack of exercise — ☐ Yes : _____

Chemical Stress

Explanation

1. Take prescription or over the counter medication — ☐ Yes : _____
2. Consume alcohol — ☐ Yes : _____
3. Use tobacco products — ☐ Yes : _____
4. Use artificial sweeteners (aspartame, sucralose) — ☐ Yes : _____
5. Poor diet (fast food, flour, sugar) — ☐ Yes : _____
6. Environmental pollution — ☐ Yes : _____

Emotional Stress

Explanation

1. Divorce of parents or spouse — ☐ Yes : _____
2. Death of a loved one — ☐ Yes : _____
3. Serious illness (self or a loved one) — ☐ Yes : _____
4. Financial concerns — ☐ Yes : _____
5. Procrastination — ☐ Yes : _____
6. Worry and/or fear — ☐ Yes : _____
7. Work environment — ☐ Yes : _____
8. Relationships — ☐ Yes : _____
9. Low self-esteem — ☐ Yes : _____

Thank you for filling your Confidential Health Profile!

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