



Vital Information

Name _____ Date ____/____/____

I prefer to be called _____

Address _____

City _____ State ____ Zip _____

Home # ____-____-____ Work # ____-____-____ Cell # ____-____-____

Preferred Contact # h | w | c Email _____

Birthday ____/____/____ Age ____

Occupation _____ Employer _____

Marital Status Married Domestic Partner Single Widowed

Spouse/Partner Name _____

Do you have children? y | n How many? _____

Names & Ages of all Children _____

Reason for seeking our services? _____

What other action steps have you taken? _____

Who can we thank for referring you to **Café of Life**? _____

Have you ever been adjusted by a Chiropractor? y | n

Who & Where? _____ Date of last adjustment? ____/____

Do you have a Primary Care Provider? y | n

Who & Where? _____

Is there anything about your Nerve System and Spine we should know about? _____

Additional comment(s) _____

Date: ____/____/____
First Name: _____
Last Name: _____



Stress Profile

Chiropractic is based upon the location and adjustment of vertebral subluxations. **Subluxations** are caused by any stress your body cannot properly perceive, adapt to, or integrate. These stresses may be physical, chemical, or emotional/mental in nature. Please circle the stresses that you've experienced as a child, teen, and adult.

Physical Stress:

	Child	Teen	Adult	None	Explain
Birth Difficulty (as Mother or Child)	C		A	N	_____
Serious Slips/Falls	C	T	A	N	_____
Car Accidents	C	T	A	N	_____
Sports Injuries	C	T	A	N	_____
List Sports	C	T	A	N	_____
Physical Abuse	C	T	A	N	_____
Work Injuries	C	T	A	N	_____
Poor Posture	C	T	A	N	_____
Sitting on Your Wallet for Years	C	T	A	N	_____
Not Enough/Poor Sleep	C	T	A	N	_____
Extensive Computer Work	C	T	A	N	_____
Carrying Heavy Purse/Bookbag/Child	C	T	A	N	_____
Repetitive Lifting/Bending	C	T	A	N	_____
Driving for Many Hours	C	T	A	N	_____
Continuous Hours Standing/Sitting	C	T	A	N	_____
Hospitalization	C	T	A	N	_____
Bone Fracture	C	T	A	N	_____
Surgery	C	T	A	N	_____
Other	C	T	A	N	_____

Emotional Stress:

	Child	Teen	Adult	None	Explain
Difficult Break-Up/Divorce	C	T	A	N	_____
High Stress Career	C	T	A	N	_____
High Family Stress	C	T	A	N	_____
Money	C	T	A	N	_____
Recurrent Physical/Mental Illness	C	T	A	N	_____
Fast Paced Life	C	T	A	N	_____
Hold in Feelings	C	T	A	N	_____
Quick Tempered	C	T	A	N	_____
Verbal/Emotional Abuse	C	T	A	N	_____
Perfectionist	C	T	A	N	_____
Body Image Issues	C	T	A	N	_____
Made Fun Of/Teased	C	T	A	N	_____
Sickness or Loss of Loved One	C	T	A	N	_____
Difficulty Letting Go of Control	C	T	A	N	_____
Other	C	T	A	N	_____

Chemical Stress:

	Child	Teen	Adult	None	Explain
Environment (i.e. Poor Air/Water)	C	T	A	N	_____
Smoker/ Second Hand Smoke	C	T	A	N	_____
High Sugar Consumption	C	T	A	N	_____
Poor Diet	C	T	A	N	_____
Caffeine	C	T	A	N	_____
Artificial Sweeteners	C	T	A	N	_____
Energy Drinks	C	T	A	N	_____
Vaccinations	C	T	A	N	_____
Prescription Drugs	C	T	A	N	_____
Over the Counter Drugs (Advil, etc.)	C	T	A	N	_____
Recreational Drugs	C	T	A	N	_____
Alcohol Use	C	T	A	N	_____
Antibiotics	C	T	A	N	_____
Work With Chemicals	C	T	A	N	_____
Poisoning	C	T	A	N	_____
Other	C	T	A	N	_____

Date: _____

First Name: _____

Last Name: _____



Nutritional Background

Nutritional History (please check the items that apply to your typical diet)

- | | | |
|--|---|---------------------------------------|
| <input type="checkbox"/> junk food (___ x's per week) | <input type="checkbox"/> excess sugar | <input type="checkbox"/> skip meals |
| <input type="checkbox"/> microwave food (___ x's per week) | <input type="checkbox"/> artificial sweetener | <input type="checkbox"/> no breakfast |
| <input type="checkbox"/> gluten-free | <input type="checkbox"/> dairy-free | <input type="checkbox"/> vegetarian |
| <input type="checkbox"/> vegan | <input type="checkbox"/> omnivore | <input type="checkbox"/> raw food |
| <input type="checkbox"/> other special diet _____ | | |
| <input type="checkbox"/> water (# of glasses per day ____) | <input type="checkbox"/> alcohol | <input type="checkbox"/> tea/coffee |
| <input type="checkbox"/> soda | <input type="checkbox"/> energy drinks | <input type="checkbox"/> juice |
| <input type="checkbox"/> caffeine | | |

Do you relate any of the experiences checked above to your current state of health? y | n
 If yes, which ones? _____

System Challenges

Has your body communicated any of the following to you? (While they may seem unrelated to the purpose of the appointment, they can affect the overall assessment, care plan, and/or the possibility of being accepted for care.)

- | | | |
|--|--|---|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Heart Conditions | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Depression/Nervousness |
| <input type="checkbox"/> Ringing in Ears | <input type="checkbox"/> Cholesterol | <input type="checkbox"/> Mood Swings |
| <input type="checkbox"/> Vertigo | <input type="checkbox"/> Anemia | <input type="checkbox"/> ADD/ADHD |
| <input type="checkbox"/> Rashes/Eczema | <input type="checkbox"/> Numbness in Arms/Legs | <input type="checkbox"/> Vision/Hearing Changes |
| <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Cold Hands/Feet | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Constipation/Diarrhea/Gas | <input type="checkbox"/> Urinary Changes | <input type="checkbox"/> Hypo/Hyper Thyroid |
| <input type="checkbox"/> Digestions Problems | <input type="checkbox"/> Weight Changes | <input type="checkbox"/> Prostate Changes |
| <input type="checkbox"/> Ulcers | <input type="checkbox"/> Sweats/Chills | <input type="checkbox"/> Chest Pain |
| <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Night Sweats | <input type="checkbox"/> Loss of Smell or Taste |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Stomach Problems |
| <input type="checkbox"/> Tension Across Top of Shoulders | <input type="checkbox"/> Cancer | <input type="checkbox"/> HIV |
| <input type="checkbox"/> Tension Between Shoulder Blades | <input type="checkbox"/> Fatigue | <input type="checkbox"/> PMS |
| <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Asthma | <input type="checkbox"/> Fever |
| <input type="checkbox"/> Loss of Sleep | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Heartburn | <input type="checkbox"/> Other _____ | |

Questions for Women

- | | | |
|---|---|---|
| <input type="checkbox"/> past pregnancy | <input type="checkbox"/> currently pregnant | <input type="checkbox"/> breast-feeding |
| <input type="checkbox"/> birth control pills/patch/ring | <input type="checkbox"/> painful periods | <input type="checkbox"/> irregular cycles |

Other Avenues of Healing

Have you had or do you use any of the following for your growth, healing and development?

- | | | |
|---|--|---|
| <input type="checkbox"/> Massage/Bodywork | <input type="checkbox"/> Homeopathy/Herbalist | <input type="checkbox"/> Nutritional Cleansing |
| <input type="checkbox"/> Emotional Therapy/Psychotherapy | <input type="checkbox"/> Naturopathic Medicine | <input type="checkbox"/> Nutritional Counseling |
| <input type="checkbox"/> Physiotherapy/Occupational Therapy | <input type="checkbox"/> Ayurvedic Medicine | <input type="checkbox"/> Breathwork/Re-birthing |
| <input type="checkbox"/> Music/Dance/Sound/Light/Aromatherapy | <input type="checkbox"/> Acupuncture | <input type="checkbox"/> Feldenkrais |
| <input type="checkbox"/> Yoga/Pilates/Dance/Tai Chi | <input type="checkbox"/> Cranial-Sacral | <input type="checkbox"/> Other _____ |

Date: ___/___/___
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 Last Name: _____



Life Inventory

Please rate these different areas of your life expression on a scale of 1-10.

1 = extremely dissatisfied. 10 = completely fulfilled.

- Energy level _____
- Clarity of thought _____
- Physical Flexibility and Ease _____
- Mental Flexibility _____
- Emotional Balance _____
- Level of Pain _____
- Sleep quality _____
- Connection to God/Spirit/Source _____
- Feelings of Abundance _____
- Level of Joy in Life _____
- Relationships _____
- Sense of Peace/Hope _____
- Ability to Adapt to Change _____
- Overall Health & Wellbeing _____

Clarifying Your Intentions

What do you hope to receive from our care? (i.e. full, abundant health and well-being, pain relief, reconnection of my spiritual/physical body, etc.)

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

High | Medium | Low

Date: _____ / _____ / _____
First Name: _____
Last Name: _____



Philosophical Agreement

A **Café of Life** exists to make a positive contribution in your Life, by assisting you to heal naturally and to enjoy abundant health and wellbeing. **The Practice of Chiropractic** is based on ageless principles governing health and healing. They are briefly explained below so that you may understand how Chiropractic can help you.

Life Force is the sole difference between life and death. From the moment of conception until your last breath, Life Force is the essence that sustains you. You can live for some time without food, water, sleep, exercise and even air, yet you cannot live an instant without Life Force. Life Force is the essential ingredient in health and healing. It is the power that runs and heals your body. **Healing** is the creation of new cells to replace old, sick or damaged ones. Cellular replacement is how your body heals and repairs naturally. When new healthy cells are created regularly you stay well and healthy. Life Force is generated by the brain and flows through your spinal cord and nerve network to stir every tissue cell of your body into aliveness.

The **Nerve System** is also the medium used for the transfer of vital information essential for all Human Works-from healing to body functions, emotions, creativity, performance and self-expression. Your Nerve System is your link between the inner and outer world. It consists of the brain, the spinal cord, the nerves and the dazzling array of neurotransmitters. The extensiveness of the Nerve System is such that your Nerve System and **Immune System** are in fact one; therefore a Nerve System at ease rather than stressed or tense, leads to a stronger immunity. Your body functions at its best.

Blockages and interferences to your **Nerve System** develop throughout life from physical, emotional or chemical stressors. This interferes with your normal physiology. With time, dis-ease, mal-function, symptoms, sickness and disease manifest. These symptoms are the effects rather than the cause. **Chiropractic addresses cause rather than the effects.**


A **free flow in brain to body communication** enhances your ability to heal, repair and be healthy. When messages from your brain travel freely to all parts of your body, you express and experience Life fully. Healing, wellbeing, increased performance and greater personal expression are the natural byproducts.

Chiropractic adjustments free up Life Force and the flow of messages between the brain and body, by removing blockages and interferences to the Nerve System. It allows every individual whether a newborn, an athlete or a grandparent to heal, repair and experience more vitality. Due to a greater Life Force flow, all areas of a person's life improve. In some individuals, physical, emotional and/or mental challenges may clear up quickly; in others the process is slower or partial. Yet everyone will benefit on some levels. The power of the adjustment is remarkable.

Chiropractic is not a substitute, an alternative or a preventative form of medicine. **Chiropractic specializes in the expression of life, health, wellness, healing and wellbeing.** Medicine specializes in the diagnosis and treatment of symptoms, sickness and disease. One is not exclusive of the other; both are separate and distinct professions.

Rather than diagnose, treat or prognose any physical, mental or emotional ailments which is the practice of Medicine, we free Life Force through adjustments. We share information and impart knowledge about natural healing, health, wellness and wellbeing, which is the practice of Chiropractic. Our primary goal is your health, healing process and wellbeing. We are here to support you.

I (We), _____ & _____ the undersigned, have completely read and understood the above statement and choose to receive care.

Signature  _____

Date ____/____/____

Date: _____

First Name: _____

Last Name: _____



Health Care Authorization Form

I have been provided with a copy of the Notice of Privacy Practices for Protected Health Information. The Notice of Privacy Practices describes the types of uses and disclosures of my Protected Health Information (PHI) that will occur in my care, payment of my bills or in the performance of health care operations of this Chiropractic office. A copy of our notice is available on our website (www.livelovethrive.com) and we encourage you to read it and request your own copy if you would like one.

This notice of Privacy Practices also describes the rights and duties of the Chiropractor with respect to my protected health information. I hereby give permission to use and/or disclose Protected Health Information in accordance with the following:

SPECIFIC AUTHORIZATIONS

- I give permission to use my address, phone number, and clinical records to contact me with appointment reminders, missed appointment notification, birthday cards, holiday related cards, newsletters, information about health care or other health related information.
- If the Café of Life contacts me by phone, I give them permission to leave a phone message on my answering machine or voice mail.
- I give permission to the Café of Life to use my name on a welcome board, referral board, and birthday board.
- I give permission to the Café of Life to use my photograph on their bulletin board and other informational material such as their brochure, website, and articles in print media.
- I give permission to the Café of Life to use any testimonial written by me for informational purposes such as sharing with other clients or prospective clients, in their brochure, on their website, or in ads in print media.
- I give the Café of Life permission to adjust me in an open room where others are also being adjusted. I am aware that other persons in the office may overhear some of my protected health information during the course of care. Should I need to speak with the Chiropractor at any time in private, the Chiropractor will provide a room for these conversations.

By signing this form you are giving the Café of Life permission to use and disclose your Protected Health Information in accordance with the directives listed above.

The use of this format is intended to make your experience at the Café of Life more efficient and productive as well as to enhance your access to quality Chiropractic Care and health information. This authorization will remain in effect for the duration of my care at the Café of Life plus 7 years or until revoked by me.

RIGHT TO REVOKE AUTHORIZATION

You have the right to revoke this AUTHORIZATION in writing at any time. However, your written request to revoke this AUTHORIZATION is not effective to the extent that we have provided services or taken action in reliance on your AUTHORIZATION.

You may revoke this AUTHORIZATION by mailing or hand delivering a written notice to the Café of Life. The written notice must contain the following information:

- Your name, Social Security number, and date of birth;
- A clear statement of your intent to revoke this AUTHORIZATION;
- The date of your request; and
- Your signature



The revocation is not effective until it is received by the Café of Life.

This AUTHORIZATION is requested by the Café of Life for its own use / disclosure of PHI. *(Minimum necessary standards apply.)*

I have the right to refuse to sign this AUTHORIZATION. If I refuse to sign this AUTHORIZATION, the Café of Life will provide care, however, it will not be possible for the Café of Life to file third party billing on my behalf and I will be responsible for: 1) payment in full at the time services are provided to me 2) scheduling my own appointments since the Café of Life will be unable to contact me 3) all contact with the Café of Life regarding my care. Additionally, any collection activity as permitted by law is not waived by refusal to sign the authorization.

I have the right to inspect or copy, with boundaries, the Protected Health Information to be used / disclosed. A reasonable fee for copying will apply. A copy of the signed authorization will be provided to me.

HEALTHCARE AUTHORIZATION

Date: _____
First Name: _____
Last Name: _____

I have read and understand this Healthcare Authorization Form and acknowledge receipt of The Notice of Privacy Practices for Protected Health Information. My signature below represents agreement with these practices.

SSN _____ - _____ - _____ D.O.B. ____/____/_____

Name (Print) _____

Signature X _____ Date ____/____/_____

Name of Personal Representative (If someone other than yourself is designated to act on your behalf)

Name (Print) _____

Personal Representative X _____ Date ____/____/_____

Description of Representative's Authority To Act On your Behalf:



Insurance Policy

Only fill out if you choose to utilize your insurance.

Recommendations for care are based on necessity and not insurance benefits. Please understand that insurance companies pay for sick-care, not wellness care as provided by the Café of Life. Many times your insurance benefits may contribute to the cost of your care here at the Café. Your insurance policy is between you and your insurance company, not between your insurance company and us. We are happy to offer to do your insurance billing for you with full understanding that the cost for service rendered to you by the Café of Life Chiropractic is your personal responsibility. If applicable, we will accurately bill your insurance company for services.

ANTHEM BLUE CROSS/BLUE SHIELD or OTHER INSURANCE WHICH PAYS DIRECTLY TO PATIENT

If you request us to direct bill your insurance company which pays directly to you, our office policy is that you leave a credit card on your account to cover the costs in the event you should receive insurance checks for our services and not return them. The credit card will only be used should you fail to provide our office with the funds within 5 days of receiving them or call to let us know you will bring the checks on your next appointment. We receive updates from all insurance companies of insurance check disbursements.

I, _____, understand it is my responsibility to return all Explanation of Benefits (EOB) and Reimbursement Checks to Café of Life Chiropractic promptly. If I fail to do so within one week of receiving the check(s), I authorize charges to my credit card for the amount of the check(s).

Name as shown on card _____
 Credit Card Acct. # _____ Exp. Date ____/____/____
 Type VISA MC AMEX DISCOVER 3 Digit Security Code _____ (4 digit for AMEX)

Date: _____
First Name: _____
Last Name: _____

I CLEARLY UNDERSTAND AND AGREE that all services rendered me are charged directly to me and that I am personally responsible for payment. I agree that I am responsible for all bills incurred at this office relating to my care. I also understand that I may suspend or terminate my care, all fees for professional services rendered me will become immediately due and payable. I agree that if I fail to provide the Café of Life with payments made in my name for services rendered at the Café, I give the Café the right to charge said credit card for the exact amount that the insurance company state was paid to me. I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to the provider for services rendered.

I (We), _____ & _____ the undersigned, have completely read and understood the above statement concerning insurance and choose to receive care.

Signature *X* _____ Date ____/____/____

Our Mission is to serve every human being with respect, compassion, gratitude, and love. We will strive to provide the exceptional chiropractic experience through the chiropractic adjustment and the teaching of our body's magnificent innate potential. We aim for excellence, mastery, and constant growth while enjoying the perfection of the process itself.