Dr. April E. Warhola
Family Chiropractor
404.917.4992

Café of Life in Grant Park
1030 Grant St SE
Atlanta, GA 30315

Vital Information

Today's Date: _____

Participant's Legal Name: _____
What name would you like us to use? _____
Address_____City_____Zip_____
Date of Birth_____ Age____ Gender _____Height _____ Weight_____
Home or Cell Phone _____ Work Phone _____
Best number to contact you: (circle one) Cell / Work
Email Address _____ may we use this email address to contact you? Y / N

Marital Status: Married ~Domestic Partner~ Single~ Widowed~ Divorced (circle one)
Name of Spouse/Partner_____
Do you have children? Y/N
#of Children____ Name and Age of children: _____
_____ Do they live at home? Y / N

Employed By _____ Occupation _____
Please Provide and **EMERGENCY CONTACT PERSON AND PHONE NUMBER:**
_____

Who can we thank for referring you to us? _____

Life Story

Name: _____ Date: _____

Please write your answers to the following:

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

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

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

Chiropractor's Comments:

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 WHAT/What For and DAILY Dosage:

Please Tell Us About Your Life Stressors

Name: _____ Date: _____

Physical Stress	Past/Present	Please Explain
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

Please Sign and Date: _____

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