



Café of Life Wellness

Dr. Jennifer Hastings, D.C.

Date _____

Name _____ Soc # _____

Address _____ City _____ Zip _____

Date of Birth _____ Age _____ Gender _____ Height _____ Weight _____

Email Address _____

Home Ph _____ Business Ph _____ Cell Ph _____

Employed by _____ Occupation _____

Best number to contact you: (check one)

- Home
- Business
- Cell

Marital Status: (check one)

- Married
- Domestic Partner
- Single
- Widowed
- Divorced

Name of Spouse/partner _____ Do you have children? Y N

of children _____ Do they live at home? _____

Reason for seeking services at the Café of Life?

Who can we thank for referring you to us?

Is there anything about your Nerve System and/or Spine we should know about? (previous surgeries)

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

- High
- Medium
- Low

Additional Comments

Life Story

Please tell us about you. Be as specific as possible.

Name _____ Date _____

Briefly describe your nutrition breakfast, lunch and dinner:

What is your daily fluid intake?

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 you family relationships? (i.e. good, stressful, none)

Rank your satisfaction with work (not satisfied) 1 2 3 4 5 6 7 8 9 10 (very satisfied)

What type of work do you do?

How often do you vacation?

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

What are our play & relaxation activities?

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

Name _____ Date _____

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	Fatigue	Sweats	Heart Condition	Depression
Nervousness	Numbness Arms/Legs	Other _____		

The following three areas of stress can cause a misaligned vertebra (subluxation).

Do you recognize any of these?

C=child T=teenager A=adult N=not at all

1. Physical Stress

EXPLAIN

Birth Trauma (as mother or child)	C	T	A	N	_____
Slips/Falls	C	T	A	N	_____
Car Accidents	C	T	A	N	_____
Sports Injuries	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	_____
Sleeping Position (i.e. stomach, side)	C	T	A	N	_____
Extensive Computer Work	C	T	A	N	_____
Carrying Heavy Purse/Bag/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	_____
Bone Fracture/Surgery	C	T	A	N	_____

2. Emotional Stress

Relationship	C	T	A	N	_____
Career	C	T	A	N	_____
Children	C	T	A	N	_____
Money	C	T	A	N	_____
Fast Paced Life	C	T	A	N	_____
Holding in Feelings	C	T	A	N	_____
Quick Tempered	C	T	A	N	_____
Verbal Abuse	C	T	A	N	_____
Perfectionist	C	T	A	N	_____
Procrastinator	C	T	A	N	_____
Sickness or Loss of Loved One	C	T	A	N	_____

3. Chemical Stress

EXPLAIN

Environment (i.e. pollution)	C	T	A	N	_____
Smoker-Amount	C	T	A	N	_____
Second Hand Smoke	C	T	A	N	_____
Poor Diet	C	T	A	N	_____
Caffeine-Amount	C	T	A	N	_____
Artificial Sweeteners	C	T	A	N	_____
Prescription Drugs	C	T	A	N	_____
Over the counter drug (Advil, Tylenol)	C	T	A	N	_____
Recreational Drugs	C	T	A	N	_____

Name _____

Date _____

What do you feel is your primary stress?

What other things have you done to improve your health and well-being?

(circle all that apply)

Massage Acupuncture Yoga Meditation Homeopathy Herbs Run
Supplements Cleanse Consume Organic Foods Pilates Nutritionist
Personal Trainer Physical Therapist Other _____
Chiropractor, Who: _____ Date of Last Adjustment: _____
Frequency of visits: _____ times per week/month
Duration of care: _____ weeks/months/years

For Women Only

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

Café of Life
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