



DR. CHRIS KRAMP B.Sc. D.C.
 210-4910 Roblin Blvd, Winnipeg, MB R3R 0G7
 TEL (204) 885-3858 FAX (204) 885-4945
 info@krampchiropractic.com

Name: _____ Age: _____ Date: _____

Address: _____ City: _____ Prov: _____ Postal Code: _____

Email Address: _____ Send me monthly e-newsletter: Yes No

Home Phone #: () _____ Work: () _____ Cell: () _____

Birth Date: _____ Male Female Type of Employment: _____

Single Married Divorced Widowed Spouse's employment: _____

of children: _____ Have you ever seen a chiropractor before? Yes No If so, when? _____

Reason for consulting our office: _____

Who referred you to our office? _____

Amount of Health Coverage for: Chiropractic _____ Massage _____ Orthotics _____

Why this Form is Important

As a full spectrum Chiropractic office, we focus on your ability to be healthy. Our goals are to address the issues that brought you to this office and offer you the opportunity of improved health potential and wellness services in the future. On a daily basis we experience physical, chemical and emotional stresses that can accumulate and result in serious loss of health potential. Most times the effects are gradual: not even felt until they become serious. Answering the following questions will give us a profile of the specific stresses you have faced in your lifetime, allowing us to better assess the challenges to your health potential.

The Beginning Years (To Age 17)

Research is showing that many of the health challenges that occur later in life have their origins during the developmental years, some starting at birth. Please answer the following questions to the best of your ability.

	Yes	No	Unsure	Comments:
Did you have any childhood illnesses?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Was there any prolonged use of medicine such as antibiotics or an inhaler?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Did you have any serious falls as a child?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Did you play youth sports?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Were you vaccinated?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Did you take/use any drugs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Were you under regular Chiropractic care?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Did you have any surgery?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you fallen/jumped from a height over three feet? (i.e. crib, bunk bed, tree)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Were you involved in any car accidents?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

The Adult Years (Age 18 to Present)

Do/did you smoke?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do/did you drink alcohol?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you been in any accidents?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you had any surgery?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do/did you play any adult sports?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do/did you participate in extreme sports?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

The Major Symptom / Complaint

While our goal is to increase your overall health we realize that you may have come here with a specific complaint, please use this next section if you are suffering from any conditions you wish us to address.

List the major symptom or complaint you may be living with:

If you are experiencing pain, is it....

- Sharp Dull Constant Travels Comes and goes

Since the problem started, is it....

- About the same Getting better Getting worse

It worsens when:

It interferes with:

- Work Sleep Walking Sitting Hobbies Leisure

Other doctors seen for this problem:

Chiropractor _____

Medical _____

Other _____

Your Overall Health

The majority of the patients that come to our office do not realize that there are many areas where we can help improve their health. Please fill out this section to help us have a clearer picture of your overall health.

On a scale of 1-10 describe your stress level: (1 = none, 10 = extreme)

Occupational: _____ Personal: _____

On a scale of POOR, GOOD, or EXCELLENT describe your:

Diet: _____ Exercise: _____ Sleep: _____ General Health: _____

Please check all symptoms you have had in the past year, even if they do not seem related to your current problem.

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Pins and needles in arms | <input type="checkbox"/> Constipation | <input type="checkbox"/> Trouble Sleeping |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Numbness in fingers | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Cold Sweats |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Cold hands | <input type="checkbox"/> Problem Urinating | <input type="checkbox"/> Hot Flashes |
| <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Back Pain | <input type="checkbox"/> Menstrual Pain | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Lights bother eyes | <input type="checkbox"/> Tension | <input type="checkbox"/> Menstrual Irregularity | <input type="checkbox"/> Mood Swings |
| <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Heartburn | <input type="checkbox"/> Numbness in toes | <input type="checkbox"/> Irritability |
| <input type="checkbox"/> Loss of Taste | <input type="checkbox"/> Upset Stomach | <input type="checkbox"/> Pins and needles in legs | <input type="checkbox"/> Nervousness |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Cold feet | <input type="checkbox"/> Depression |

List any medications you are taking:

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for evaluation.

Signature: _____ **Date:** _____