



**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

## Pediatric Form

Child's Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Prov: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Home Phone #: ( ) \_\_\_\_\_ Birth Date: \_\_\_\_\_ Male  Female

Parent's Name: \_\_\_\_\_

Has your child 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

The vast majority of our pediatric patients have experienced literally dozens of impacts that could cause subluxated vertebrae. Subluxated vertebra can cause irritation to different fibers within nerves that can affect any organ or tissue, causing conditions now or in the future. Depending on the type and degree of the subluxated vertebra, the nerve pressure can be constant or occasional. Our goals are to address the issues that brought you to this office and offer your child the opportunity of improved health potential and wellness services in the future. Our only method is specific adjustments to correct vertebral subluxations. We believe the greatest Doctor is the one already inside each of our patients and we only help to maximize their inherent healing power without the use of drugs or surgery.

### Birth Story

How long was labor? \_\_\_\_\_ How long did mother actually push? \_\_\_\_\_ Was mother induced? Yes  No

Nerve block? Yes  No  C-section? Yes  No  Head pulled? Yes  No  Forceps/vacuum? Yes  No

Additional comments: \_\_\_\_\_

### Childhood Illnesses

List any illnesses experienced: \_\_\_\_\_

List all current medications: \_\_\_\_\_

Has your child received vaccinations? All  Some  None  Has your child had any surgeries? Yes  No

### Falls

Has your child fallen/jumped from a height over three feet? (ie. crib, bunk bed, tree) Yes  No

When was the most recent fall? \_\_\_\_\_ Any care given? \_\_\_\_\_

And the fall before that? \_\_\_\_\_ Any care given? \_\_\_\_\_

### Accidents

Has your child been involved in a motor vehicle accident as a passenger? Yes  No

Briefly describe: \_\_\_\_\_

Any treatment received? \_\_\_\_\_

## Sports/Recreation

What sports or recreational activities does your child do? \_\_\_\_\_

When was the most recent stress, strain, or injury while doing these activities? \_\_\_\_\_

Any care given? \_\_\_\_\_

## Current Health Concerns

Please check any symptoms that your child has or has had previously:

- |  |   |   |  |
|--|---|---|--|
| <input type="checkbox"/> Headaches/Migraines | <input type="checkbox"/> Asthma                 | <input type="checkbox"/> Sleep problems | <input type="checkbox"/> Weight problems       |
| <input type="checkbox"/> ADD/ADHD            | <input type="checkbox"/> Postural Imbalance     | <input type="checkbox"/> PDD/Autism     | <input type="checkbox"/> Seizures              |
| <input type="checkbox"/> Frequent colds      | <input type="checkbox"/> Allergy/Sinus problems | <input type="checkbox"/> Bedwetting     | <input type="checkbox"/> Ear infection         |
| <input type="checkbox"/> Colic               | <input type="checkbox"/> Digestive problems     | <input type="checkbox"/> Scoliosis      | <input type="checkbox"/> Growing/Back problems |

Comments: \_\_\_\_\_

List any allergies: \_\_\_\_\_

List any genetic disorders: \_\_\_\_\_

List any other conditions: \_\_\_\_\_

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

**Parent's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_