Kramp Chiropractic

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Name: _____ Age: _____ Today's Date: DD/MM/YYYY

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

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

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

Birth Date: DD/MM/YYYY Male ☐ Female ☐ Other ☐ Type of Employment: _____

Single ☐ Married ☐ Divorced ☐ Widowed ☐ Number of children: _____ Number of children birthed: _____

Have you ever seen a chiropractor before? Yes ☐ No ☐ If yes, who and when? _____

How did you hear about us? Family☐ Friend☐ Google☐ Facebook/Instagram☐ Other: _____

Reason for consulting our office: _____

Would you like appt reminders? Yes ☐ No ☐ If yes, what method is preferred? Email ☐ Text ☐ Phone Call ☐

Why do we need all of this information?

The questions below are designed to help us understand your unique and optimal path back to health and a life you love! Our first priority is to get you out of pain. The second, to keep you out of it! Science is showing how the physical, chemical and emotional stresses we encounter each day can compound quickly, with often the last symptom being pain and discomfort. The truth is, our health can be deteriorating even when we don't feel it. The information below will provide a snapshot of the specific stresses you have/are facing and allow us to better address the issues we all face that interfere with our body's ability to heal.

Your Beginning Years (To Age 17)

Research is showing that many of the health challenges we face later in life actually have their origins in our developmental years, even birth. Please answer these questions to the best of your ability.

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

Your Adult Years (Age 18 to Present)

Do/did you smoke?	☐	☐	☐	
Do/did you drink alcohol?	☐	☐	☐	
Have you been in any accidents?	☐	☐	☐	
Have you had any surgery?	☐	☐	☐	
Do/did you play any adult sports?	☐	☐	☐	
Do/did you participate in extreme sports?	☐	☐	☐	

Your Major Symptoms / Complaints

With the goal of continually pursuing your optimal overall health, we certainly realize that you may have come here with a specific complaint. Please use this next section to outline any current conditions, pain or discomfort you wish us to address.

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

_____

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

☐ Sharp ☐ Dull ☐ Constant ☐ Travels ☐ Comes and goes

Since the problem started, it is....

☐ Staying 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

With the aim of improving your overall health and enjoyment of life, the questions below will help us identify other areas that we have seen chiropractic care successful in treating. Please fill out this section to help us get a better 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.

☐ Headaches	☐ Pins and needles in arms	☐ Constipation	☐ Trouble Sleeping
☐ Dizziness	☐ Numbness in fingers	☐ Diarrhea	☐ Cold Sweats
☐ Fainting	☐ Cold hands	☐ Problem Urinating	☐ Hot Flashes
☐ Loss of Balance	☐ Back Pain	☐ Menstrual Pain	☐ Fatigue
☐ Lights bother eyes	☐ Tension	☐ Menstrual Irregularity	☐ Mood Swings
☐ Ringing in ears	☐ Heartburn	☐ Numbness in toes	☐ Irritability
☐ Loss of Taste	☐ Upset Stomach	☐ Pins and needles in legs	☐ Nervousness
☐ Neck Pain	☐ Ulcers	☐ Cold feet	☐ 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:** _____