



**DR. CHRIS KRAMP B.Sc. D.C.**  
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Name: \_\_\_\_\_ Age: \_\_\_\_\_ Today's Date: MM/DD/YYYY

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

Email Address: \_\_\_\_\_ Send me monthly e-newsletter: Yes  No

Home Phone #: (\_\_\_\_) \_\_\_\_\_ Work: (\_\_\_\_) \_\_\_\_\_ Cell: (\_\_\_\_) \_\_\_\_\_

Birth Date: MM/DD/YYYY 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, and allow 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, 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

The majority of the patients that come to our office do not realize that there are many areas in which 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:** \_\_\_\_\_