

Chiropractie Kramer Patient Health History Form

In order to provide you the best possible care, please complete this form and bring it to your first appointment. All information is strictly CONFIDENTIAL.

Patient Data		
First Name:	<input type="text"/>	Last Name: <input type="text"/> D.O.B: <input type="text"/>

Mailing address / Info		
Address	<input type="text"/>	City <input type="text"/> Post Code <input type="text"/>
Phone(mobile)	<input type="text"/>	(home) <input type="text"/>
Email	<input type="text"/>	Referred By <input type="text"/>
Occupation	<input type="text"/>	Hobby's/Sport <input type="text"/>
Marital Status	<input type="text"/>	Spouse's name <input type="text"/> # of Childeren <input type="text"/>

Current Complaints	
Describe the Nature of your Complaint:	<input type="text"/>
Date symptoms appeared	<input type="text"/> Date of Injury <input type="text"/>
Have you ever had same condition?	<input type="radio"/> No <input type="radio"/> Yes If Yes, when? <input type="text"/>
List of other practitioners seen for this injury/condition	<input type="text"/>
Have you ever been under chiropractic care?	<input type="radio"/> No <input type="radio"/> Yes <input type="text"/>
If yes, please describe	<input type="text"/> <input type="text"/>

Medical Information	
Name Medical Doctor / Clinic	<input type="text"/> City <input type="text"/>
Insurance company	<input type="text"/> <input type="text"/> <input type="text"/>
Policy #	<input type="text"/> <input type="text"/>
	<input type="text"/> <input type="text"/>

Signatures	
Patient name	_____
Patient's signature	_____ Date _____
Spouse's or guardian's signature	_____ Date _____

Medical History

Have you been treated for any conditions in the last year? Please describe...

MRI Scans &/or X-rays? No Yes If Yes, where?

What medications are you taking and for what conditions (Please list dosage and amounts, etc)

What supplements do you currently take? (Please list for what conditions, dosage, and frequency)

Have you ever:	No	Yes	Briefly Explain
Broken bones?	<input type="radio"/>	<input type="radio"/>	
Been hospitalized?	<input type="radio"/>	<input type="radio"/>	
Been in an auto accident?	<input type="radio"/>	<input type="radio"/>	
Had Sprains/Strains?	<input type="radio"/>	<input type="radio"/>	
Been struck unconscious?	<input type="radio"/>	<input type="radio"/>	
Had surgery?	<input type="radio"/>	<input type="radio"/>	

Family History

Family Members - Present and past health conditions (Example: heart disease, cancer, diabetes, arthritis, etc.)

Do you experience pain every day?	<input type="radio"/> No	<input type="radio"/> Yes
Do your symptoms interfere with daily life?	<input type="radio"/> No	<input type="radio"/> Yes
Does pain wake you up at night?	<input type="radio"/> No	<input type="radio"/> Yes
Are your symptoms worse during certain times of the day?	<input type="radio"/> No	<input type="radio"/> Yes
Do changes in weather affect your symptoms?	<input type="radio"/> No	<input type="radio"/> Yes
Do you wear orthotics?	<input type="radio"/> No	<input type="radio"/> Yes
Is there a chance you are pregnant?	<input type="radio"/> No	<input type="radio"/> Yes
What activities aggravate your symptoms?	<input type="radio"/> No	<input type="radio"/> Yes

Habits	None	Light	Moderate	Heavy
Alcohol	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Coffee	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Tobacco	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Drugs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Exercise	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sleep	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Appetite	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Soft Drinks	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Water	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Salty Foods	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sugary Foods	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Artificial Sweeteners	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Have you ever suffered from:

- Alcoholism
- Allergies
- Anemia
- Arteriosclerosis
- Arthritis
- Asthma
- Back Pain
- Breast Lump
- Bronchitis
- Bruise Easily
- Cancer
- Chest Pain/Conditions
- Cold Extremities
- Constipation
- Cramps
- Depression
- Diabetes
- Digestion Problems
- Dizziness
- Ears Ring
- Excessive Menstruation
- Eye Pain or Difficulties
- Fatigue
- Frequent Urination
- Headache
- Hemorrhoids
- High Blood Pressure
- Hot Flashes
- Irregular Heart Beat
- Irregular Cycle
- Kidney Infection
- Kidney Stones
- Loss of memory
- Loss of balance
- Loss of smell
- Loss of taste
- Lumps In Breast
- Neck Pain or Stiffness
- Nervousness
- Nosebleeds
- Pacemaker
- Polio
- Poor Posture
- Prostate Trouble
- Sciatica
- Shortness of breath
- Sinus Infection
- Sleep problems or Insomnia
- Spinal Curvatures
- Stroke
- Swelling of ankles
- Swollen Joints
- Thyroid Condition
- Tuberculosis
- Ulcers
- Varicose Veins
- Venereal Disease
- Other _____

Please use the following letters to indicate TYPE and LOCATION of the symptoms you currently are experiencing.

A=Ache O=Other
 B=Burning P=Pins & Needles
 N=Numbness S=Stabbing

