Krieger Health Solutions
New Patient Health History

Name: ____DOB _____________Date ____________

Address ________________________________City _________________ State ______ Zip _______

Email ___________________________________Occupation ________________________________

Phone _______________________Cell _______________________Work _____________________

Sex: M __ F __ Married __ Single __ Divorced __ Widowed __

Kids: Yes __ No __ How many____ Ages ____ ____ ____ ____

How did you hear about our clinic? ____

Childhood History (if applicable please fill out for child):

Did you have any childhood diseases? Yes No
Did you have any serious falls as a child? Yes No
How many? ___
Did you play sports? Yes No
Which sports? ____
For how many years? ___
Were you ever diagnosed with a concussion? Yes No
How many times? ____
Did you break any bones? Yes No
Which bones? ____
Did you take medications? Yes No
Was there any prolonged use of medication ie: antibiotics or an asthma inhaler? Yes No
Which medications?____
For what reason(s)____
Were you vaccinated? Yes No
Starting at what age? _____
Did you have any adverse reactions to vaccines? Yes No
At what age(s)? ________ What reactions? ________________________________
Did you have surgery? Yes No
Did you fall/jump from a height of more than three feet? Yes No
Were you in any car accidents as a child? Yes No
How many? ____ What age(s) were you? ____ ____ ____
As a child did you receive chiropractic care? Yes No
If yes, did you receive chiropractic care regularly ___ or on an "as needed" ___ basis?

Did you suffer any other traumas either emotional or physical? Yes No
If yes, please describe____

Please share any other information you feel may be pertinent __________________________

____

Adult (18 and older)

Did/do you smoke? Yes No When did you quit? ________________ N/A

Did/do you drink alcohol? Yes No How many glasses/day __ week __ month __?

How many motor vehicle accidents have you been in? ___ When was the last one? __________

Have you any surgery? Yes No How many? ___When was the most recent? _____

What kind of surgeries have you had?

____

Did/do you play adult sports?Yes No What sports do you play? ____________________

____

Have you been injured playing sports? Yes No When was the last injury? _________________

<u>Addressing issues that may have brought you to our office today:</u>

If you have no symptoms or complaints and here for wellness services, please check here ____

Otherwise, please give us a brief explanation of what brought you to our office today:

____

____

Every chronic health problem we suffer from can be traced back to the body's inability to properly and adequately handle stress.

When stress builds up it eventually surpasses your brain's ability to manage and this will result in different kinds of body dysfunction which we then call a disease or syndrome (Peripheral neuropathy or gastric reflux, for example).

Below you will find a list of Common Stress Indicators.
Please check off those you have experienced in the last two years.

- Sleep difficulties/insomnia
- Fatigue and lack of energy
- Anxiety/depression/overwhelm
- Memory fog and forgetfulness
- High blood pressure
- Low resistance/weakened immunity
- Digestive issues/irritable bowel
- Weight gain/belly fat
- Chronic achiness
- Racing mind
- Headaches – Common and Migraine
- Feeling judgmental/negative/picky
- Cold hands or feet
- Hormonal imbalances
- Poor concentration
- Mood swings
- Accelerated aging
- Food cravings/addictions

Stress can come in three different forms. Which have you/do you experience?

(Please check all that are applicable)

1. Common Physical Stressors:

- Poor posture
- Sitting too much
- Sports injuries
- Car accidents (including "minor" fender benders)
- Overweight
- Sleeping on a poor mattress
- Inappropriate footwear
- Lifting improperly
- Standing on one leg frequently
- Lack of or unbalanced exercises
- Text neck and computer strain – causing digital dementia
- More than 4 hours per day of "screentime" on digital devices (Not desktops)
- Reading/playing on digital devices right before bed or in bed
- Less than one hour per day outdoors
- Insufficient exposure to sunlight

2. Common Chemical Stressors:

Colorings, additives, dyes in food

Caffeine

Nicotine and smoke

Alcohol

Soda

Fruit juice

Processed foods

White flour

White rice

Sugar

Corn/Vegetable/Canola Oil

Margarine

Sweets/desserts after each meal

Skip breakfast

Cosmetics, especially red or black lipstick

Air and water pollution

Drugs – street or prescribed

Poor eating habits

Electromagnetic frequencies

Dehydration

Vaccines

3. Common Emotional Stressors:

Anxiety and Worry

Fear

Loss of control

Loneliness

Depression

Financial stress

Time challenges

Peer pressure

Family stress

Frustration and disappointment

Exhaustion

Traffic

Weather

What aspect(s) of your life do you find most impacted by your body's inability to adequately deal with stress (check all that are applicable):

__ Work __ Family __ Sleep __ Walking __ Hobbies __ Leisure __ Other

Have you seen any other clinicians for this issue/these issues? Yes No

Please check all that apply: __ MD __ Chiropractor __ Massage Therapist __ Specialist(s)

What kind of specialists? __ Endocrinologist __ Functional Medicine __ Neurologist

__ Dermatologist __ Pediatrician __ OB/GYN __ Orthopedist __ Nutritionist

When was your last blood panel? _______________ Ordered by _________________________

How many times per week do you exercise? __ Once __ Twice __ Three __ More __ Less

What do you do for stress relief? ____

____

Is there anything more you would like to tell us? _____________________________________

____

____

I consent to a complete chiropractic evaluation consisting of neurological, orthopedic, metabolic and radiographic procedures. I understand that any fee for service rendered is due at the time of service and cannot be deferred to a later date.

Name ____

Signature____ Date ___________________

Guardian ____

Thank you for taking the time to provide us with this valuable information!

We know from years of experience that this information will help us to formulate a more accurate and thorough evaluation of you and your health than you have probably ever experienced before. We look forward to beginning this process with you.