Dr. Chris Grams, DC

Family Chiropractic Center

149 Finch Place SW, Suite 1 • Bainbridge Island, WA 98110 • (206) 842-6714

General Information Date: _____

Name: _____
First Middle Last

Address: _____
Street City State Zip

Phone: (Hm) _____ (Wk) _____ (Cell) _____

Email: _____Date of Birth: _____ Age:_____ Male / Female

Lifestyle Status (Circle one): Single Married Living w/Partner Separated Divorced Widowed

Emergency Contact /Phone Number:_____

Employer_____Occupation:_____

Number of Children: _____ Their Ages: _____

How do you wish to be addressed in our office? _____

How did you hear about our office? _____

Reason(s) you are consulting our office: (Check all that apply)

- ❑ I have a specific complaint and want help only with eliminating this problem.
- ❑ I am also willing to participate in strategies to insure the problem does not return.
- ❑ In addition to the above, I want to learn and do more to improve my general health.
- ❑ I have no current symptoms and feel well. I want to learn ways to keep or improve my current state of wellness.

Any Major Complaints? _____

When did this problem start?_____Have you ever had it before? Yes / No

Payment Arrangements Dr. Grams is a provider for Premera, Cigna, and Aetna Insurance Companies. Payment is expected at the time of service unless special arrangements are made in advance. Your insurance company may reimburse you. Please see our fee schedule regarding insurance. Please circle payment method:

Cash Private or group insurance (Receipts needed) Auto Accident or Personal Injury Claim

Cancellation/No Show Policy I understand my appointment time is reserved for me. Should I ned to cancel or reschedule an appointment, I must give at least 24 hours (excluding holidays and weekends) notice to allow for that time to be given to someone else, ie., Cancellation of a 9 am appointment must be received before the previous Friday. Except for a bone fide emergency, if I don't show for an appointment with less than 24 hours notice, I agree to pay the full rate of the scheduled treatment.

Client Signature:_____ Date:_____

PERSONAL HISTORY

Have you ever had your spine or nervous system examined professionally? Yes / No

If yes, when and by whom? _____

Have you ever had X-rays, CAT Scans, or MRIs of your spine or Extremities? Yes / No_____

Have you received chiropractic adjustments by a Doctor of Chiropractic? Yes / No

If yes, for how long?_____ How often did you go? _____

When was your last visit?_____ Why did you stop?_____

Were you pleased with his/her service? Yes / No _____

What type of adjustments, technique(s), or method(s) did he/she use (if known)? _____

Does your immediate family receive chiropractic adjustments? _____

Have you had, or do you receive, any of the following for growth and development?

Bodywork/Massage: Yes / No Osteopathy/Cranial work: Yes / No Prayer/Meditation: Yes / No

Psychotherapy: Yes / No Movement or Exercise: Yes / No Yoga: Yes / No

Rebirthing/Breathwork: Yes / No Other: Yes / No_____

Chiropractic practice is based upon the location and adjustment of vertebral subluxations. (Spinal) subluxations are caused by any stress your body can not properly perceive, adapt to or recover from. These stresses may be *physical*, *chemical*, or *emotional* in nature. The following questions will provide more clues about your unresolved stress levels.

PHYSICAL STRESS

BIRTHHISTORY: (Please try to obtain this information. It is important to your care.)

Did your mother have a difficult pregnancy with you? Yes / No

Explain_____

_____

Did your mother have any falls, accidents, physical injuries, or illnesses during pregnancy? Yes / No

Explain_____

_____

Were you born at: Home / Hospital / Birthing Center. Were you Incubated or Isolated after birth? Yes / No

Was your delivery traumatic? (Circle all that apply)

Drug Induced Labor Forceps Or Suction C-Section Cord Around Neck Breech Prolonged

Explain_____

_____

Were you: BottleFed Formula Bottle Fed Mother's Milk Nursed

PHYSICAL STRESS

GENERAL PHYSICAL TRAUMA

Take a few moments to reflect on your personal history before answering these questions, recalling any physical injuries you experienced since childhood.

Have you ever had any injuries that "took you out of commission"for a full day or more? Yes / No

Describe _____

Were you ever knocked unconscious? Yes / No

Have you ever used crutches, a walker, or a cane? Yes / No

Have you ever broken any bones? Yes / No _____

Have you ever had any impacts, falls, or jolts that you felt specifically may have injured your head/spine? Yes / No

Have you had extensive dental or orthodontia work performed? Yes / No

Do you grind you teeth, clench your jaw, or snore? (circle all that apply)

Which of these describe your day? (circle all that apply) Sit Stand Walk Drive

Phone work Mechanical work Repetitive work Heavy lifting

How old is your mattress? _____ Is it comfortable? Yes / No

How old is your pillow? _____ Is it comfortable? Yes / No

How often do you exercise? Daily Weekly Monthly Describe:_____

_____

SPORTS OR LEISURE

Were you previously active in any particular sports or hobbies? Yes / No Which ones?_____

_____

Are you currently active in any particular sports or hobbies? Yes / No Which ones? _____

_____

Have you been injured in any of these activities? Yes / No Comments_____

_____

Are there activities for which you spend any length of time in particular position (TV, reading, musician, etc.)? Yes / No

Comments:_____

_____

_____

_____

_____

_____

_____

_____

VEHICULAR ACCIDENTS

Have you been involved in a vehicular collision/near collision, either as the driver or as a passenger, even if you do not think you were injured? Yes / No Please list the approximate dates and severity (Mild, Moderate, Extreme).

Automobile: _____

_____

Bus, Bicycle, Motorcycle, etc. _____

_____

How do you rate your physical health since? Excellent / Good / Fair / Poor

Is it: Getting Better / About the Same / Getting Worse ?

FOOD & DIETARY HABITS / CHOICES

Please indicate how often you consume the following: (ex.: 2x/day, or 3x/week)

Alcohol _____ Artificial Sweeteners _____ Beef _____

Butter _____ Carbonated Drinks _____ Coffee _____
(Reg Or Decaf)

Dairy _____ Diet Food _____ Eggs _____
(Milk Products)

Fast Food _____ Fish _____ Fried Food _____

Fruit, Canned _____ Fruit, Fresh _____ Grains, Refined _____
(White Bread, Pasta, Etc.)

Grains, Whole _____ Margarine _____ Organic Foods _____
(Pasta, Bread, Etc.)

Pork _____ Poultry _____ Raw Food _____

Refined Sugar _____ Salt _____ Seafood _____
(Candy/Junk Food) (Added) (Shrimp, Scallops, Etc.)

Tobacco _____ Vegetables, Canned/Frozen_____ Vegetables, Fresh _____

Water _____ Fasting_____

Please list any vitamins, minerals, or herbs you take_____ _____

_____ _____ _____

_____ _____ _____

Please describe any other types of food you eat: _____

_____

How would you classify your diet? _____

_____

How would you rate your food habits? Excellent / Good / Fair / Poor

Are your food habits: Getting Better / About the Same / Getting Worse ?

Bowel movements? _____ per Day / Week Urination? _____ per day

CHEMICAL STRESS

BIRTH HISTORY

Was your mother regularly taking any drug prior to or during her pregnancy with you?

Alcohol / Tobacco / Other _____

Was her labor chemically induced or altered? Yes / No Explain _____

During your delivery, was your mother: Conscious / Semiconscious / Unconscious

Was your mother exposed to any other chemicals during her pregnancy? _____

GENERAL CHEMICAL TRAUMA:

Did you or do you work with any chemicals, fumes, dust, or smoke for long periods? Yes / No

Please list them _____

Please indicate any drugs you have taken in the Past (P), or are Currently taking (C):

Allergy/Cold/Flu	P / C	Birth Control Pills	P / C	Ulcer Medication	P / C
Antacids	P / C	Blood Pressure Meds	P / C	Vaccinations	P / C
Anti-Anxiety/Depression	P / C	Heart Medication	P / C	Other (Please List)	
Antibiotic/Antifungal	P / C	Hormones	P / C	_____	P / C
Diabetic/Insulin	P / C	Laxatives	P / C	_____	P / C
Anti-inflammatory/ Cortisone	P / C	Lithium	P / C	_____	P / C
		Recreational	P / C	_____	P / C
Antiparasitic (Worms)	P / C	Relaxants/Sleeping Pills	P / C	_____	P / C
Aspirin/Tylenol/ Ibuprofen	P / C	Stimulants	P / C	_____	P / C
		Thyroid	P / C	_____	P / C

Comments: _____

_____

EMOTIONAL STRESS

Please circle the level of severity, and whether **P**ast (P) or **C**urrent (C), for each of the following spinal stress situations

	Mild	Moderate	Extreme		Mild	Moderate	Extreme
Childhood Stress	P / C	P / C	P / C	Work-Related Stress	P / C	P / C	P / C
School Stress	P / C	P / C	P / C	Stress of Commuting	P / C	P / C	P / C
Play or Recreation	P / C	P / C	P / C	Loss of Loved One	P / C	P / C	P / C
Family Stress	P / C	P / C	P / C	Change in Lifestyle	P / C	P / C	P / C
Stress of Being Sick	P / C	P / C	P / C	Change in Vocation	P / C	P / C	P / C
Personal Relationships	P / C	P / C	P / C	Abuse (Physical, Emotional, Sexual)	P / C	P / C	P / C

How do you rate your Emotional/Mental Health? Excellent / Good / Fair / Poor

Do you feel it is getting: Better / Worse

Comments: _____

_____

_____

MEDICAL TREATMENT

Have you ever had any of the following procedures? Circle all that apply.

Bone in cast/Immobilized	Chemotherapy	Corrective shoes or bars on shoes	
Extensive diagnostic x-rays	Heel lift	Neck collar	Physical therapy
Spinal brace	Spinal injections	Spinal tap	Traction

Transfusion X-ray treatments

Have you ever been hospitalized? Yes / No When and what was done?_____

_____

_____

Have you ever had surgery? Yes / No When and what was done?_____

_____

_____

PREGNANCIES

Number of Pregnancies _____ Number of Births _____

For each pregnancy, please complete. If you need more room, please use another sheet :

1. Your age _____ Type of delivery: Normal C-Section Chemically Induced

Any falls, accidents, injuries, illnesses, or other complications? _____

_____

2. Your age _____ Type of delivery: Normal C-Section Chemically Induced

Falls, accidents, injuries or illnesses, or other complications? _____

_____

3. Your age _____ Type of delivery: Normal C-Section Chemically Induced

Falls, accidents, injuries or illnesses, or other complications? _____

_____

OTHER

Is there anything which may help us better understand you which has not been covered in this form?

_____

_____

_____

_____

_____