Welcome To

Krantz Family Chiropractic & Wellness Center

ABOUT YOU

Today's Date: _____ File #: _____

Patient Name: _____ _____ _____
Last First MI

What do you preferred to be called? _____ ○M ○F

Birthdate: _____ Age: _____ SS# _____

Address: _____

_____ _____ _____
City State Zip

Home Phone: _____ Work Phone: _____

Cell Phone: _____ E-Mail: _____

* We send appointment reminders via email and text

How tall are you? _____ Ft. _____ In. How much do you weigh? _____ Lbs.

Who can we thank for referring you/How did you hear about the office? _____

Employer: _____ How Long? _____

Address: _____ Occupation: _____

_____ _____ _____
City State Zip

Status: ○Minor ○Single ○Married ○Divorced ○Separated ○Widowed

Spouse/Partner's Name: _____

Children's Name/Age(s): _____

IN CASE OF EMERGANCY

Who should we contact? _____ Relationship: _____

Home Phone: _____ Work Phone: _____

Who is your medical Doctor? _____ Phone: _____

INSURANCE INFO

Co. Name: _____

Address: _____

_____ _____ _____
City State Zip

Phone #: _____

Insured's Name: _____

Insured's DOB: _____

Relationship to Patient: _____

ID#: _____ **Grp#:** _____

REASON FOR VISIT

Is it the result of: ○Work ○Auto ○Sport ○Trauma ○Chronic ○Wellness ○Unknown

When did it begin? _____ Explained what happened? _____

_____

Please Describe the pain and location? _____

_____

Is the condition getting worse? ○Y ○N ○Constant ○Comes and Goes

What makes it Better? _____

What makes it Worse? _____

Is the condition interfering with: ☐Work ☐Sleep ☐Daily Routine. If so, please explain: _____

_____

Have you had this or similar conditions in the past? ○Y ○N If so, please explain: _____

_____

Have you been treated by a ○Medical Physician, ○Chiropractor, ○PT for this condition? ○Y ○N

If so, whom? _____ When? _____ Phone: _____

REASON FOR VISIT

Current Health Problem(s): Reason for today's visit and **Rate 0 (no pain) to 10 (extreme pain)**

	List in order of importance	Rate 0-10	How Long?
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____

What is the quality of the discomfort? (Check all that apply)

☐Aching ☐Burning ☐Continuous ☐Deep ☐Discomfort ☐Dull ☐Frequent ☐Intense ☐Intermittent ☐Mild ☐Moderate
☐Numb ☐Occasional ☐Pain ☐Random ☐Severe ☐Sharp ☐Shooting ☐Superficial ☐Throbbing ☐Tingling ☐Tightness ☐Cramping

When is the discomfort at its worst?

☐Upon waking ☐Morning ☐Afternoon ☐Evening ☐Middle of night ☐No pattern

What treatments have you tried for this condition (if any)? _____

Check those activities below during which you experience difficulty or pain:

__ Bending backward
__ Bending forward
__ Climbing
__ Coughing
__ Dressing self
__ Getting in/out of car
__ Gripping
__ Kneeling
__ Lying on back
__ Lying flat on stomach
__ Lying on side w/knees bent
__ Pulling
__ Pushing
__ Reaching
__ Sexual activity
__ Sitting
__ Sleeping
__ Sneezing
__ Standing for over 1hr
__ Stooping
__ Turning over in bed
__ Walking
Other: _____ _____

Please Identify ALL Past (P) and any CURRENT (C) Conditions you may have/had.

MUSCULOSKELETAL
__ Arthritis
__ Back problems
__ Elbow/wrist pain
__ Foot/ankle pain
__ Herniated Discs
__ Hip disorders
__ Knee injuries
__ Low back pain
__ Neck pain
__ Osteoporosis
__ Poor posture
__ Scoliosis
__ Shoulder pain/problems
__ TMJ issues
__ Upper back pain

CARDIOVASCULAR
__ Chest pain
__ Dizziness
__ Dyspnea
__ Excessive bruising
__ Heart Attack/Stroke
__ Heart Murmur
__ Heart Surg./Pacemaker
__ High Cholesterol
__ Hypertension
__ Hypotension
__ Lower extremity bruising
__ Palpitations

GENITOURINARY
__ Blood in the urine
__ Dysuria
__ Incontinence
__ Urgency
__ Urinary frequency

NEUROLOGICAL/PSYCH
__ Anxiety
__ Depression
__ Dizziness
__ Headaches/Migraines
__ Loss of smell or taste
__ Memory issues
__ Numbness
__ Pins and needles
__ Sleeping issues

ESPIRATORY
__ Apnea
__ Asthma
__ Cough
__ Emphysema
__ Hay fever
__ Pneumonia
__ Shortness of breath
__ Wheezing

ENDOCRINE
__ Diabetes
__ Heat or cold tolerance
__ Hyperthyroidism
__ Hypothyroidism
__ Inc. in size of hands & feet
__ Pancreatic conditions
__ Polydypsia (excessive thirst)
__ Polyuria (excessive urination)
__ Purple striae (stretch marks)

HEENT
__ Blurred Vision
__ Chronic ear infections
__ Difficulty swallowing
__ Earache
__ Hoarseness
__ Recent hearing loss
__ Ringing in the ears
__ Sore throat

GASTROINTESTINAL
__ Abdominal pain
__ Blood in stool
__ Changes in bowel
__ Constipation
__ Diarrhea
__ Food sensitivities
__ Habits
__ Heartburn
__ Nausea vomiting
__ Ulcer

DERMA/HEMA
__ Bleeding
__ Blood with Stools
__ Easy bruising gum
__ Eczema
__ Excessive acne
__ Hepatitis
__ Hyper/hypopigmentation
__ New rashes
__ Psoriasis
__ Shingles
__ Skin cancer
__ Venereal Disease

Demographics and Social History

How tall are you? _____ Ft. _____ In.

How much do you weigh? _____ Lbs.

What is your shoe size? _____ Wide? ○ Y ○ N

Work: ○FT ○PT ○Unemployed ○Stay at Home

Is there a chance you are pregnant? ○ Y ○N
Due Date: _____

Mattress Age: ____ Comfortable? ○Y ○N

How many pillows do you sleep on? _____

Sleep on: ☐ Back ☐Front ☐Side ☐Stomach

Habits:

Alcohol: ○ Y ○ N - Drinks in a week? _____

Caffeine: ○ Y ○ N - How many cups a day? _____

Tobacco: ○ Y ○ N - How many packs a day? ____Pk

Recreational Drugs: ○ Y ○ N

Exercise: ○ Y ○N - Times in a week: _____

Past Medical History

When is the last time you have/had x-rays? _____
Of what? _____

Have you had any surgeries? _____

Are you on any medications? _____

Have you had any recent illnesses? _____

Any Accidents? _____

Other: _____
_____

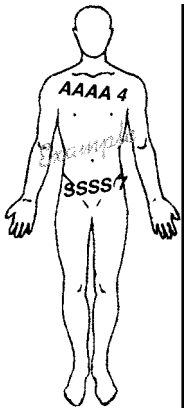
FAMILY HISTORY: (Place an **X** in any box that may apply)

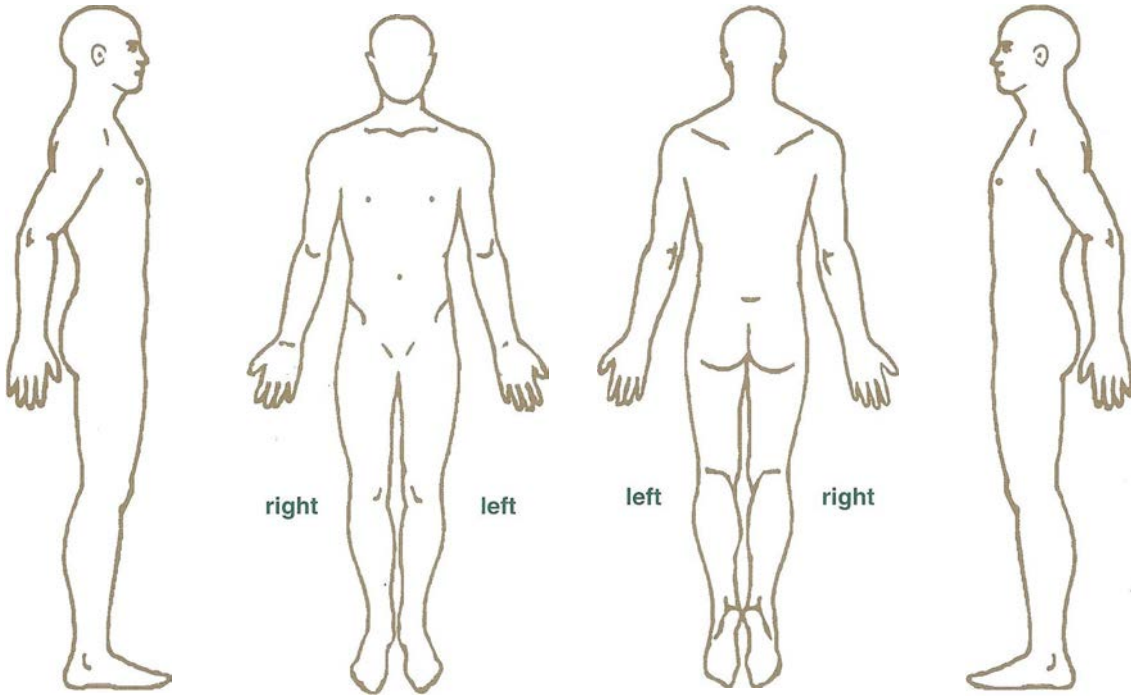
	Self	*Spouse*	*Child*		*Self*	*Spouse*	*Child*
Arthritis				Headaches			
Asthma				Neck Pain			
Back Pain				Pinched Nerves			
Carpal Tunnel				Scoliosis			
Ear Infections				Tendonitis			

Please mark **YOUR** area(s) of injury or discomfort as shown in the example below. Mark all areas with the appropriate symbols and indicate the degree of pain using a scale from 1 (discomfort) to 10 (extreme pain).

SHOW US WHERE IT HURTS

Description:	Numbness	Pins & Needles	Burning	Aching	Stabbing
Symbol:	NNNN	PPPP	BBBB	AAAA	SSSS





Right Front Back Left

-We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full or all services rendered at the time of visit, unless other arrangements have been made with the business manager in writing. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal and collection agency fees, and any other expenses incurred in collection your account.
- Unpaid balances (considered 90 days) after last visit will have a 16% annual interest rate any time you stop following your care plan or being an active patient and your balance is due immediately.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider and/or managed care organization, to release any information required to process insurance claims.
- I undersigned, do hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant to HIPAA and have been advised that a full copy of this office's HIPAA Compliance Manual is available upon request.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information i have provided.

Signature _____ ***Date*** _____

○ Adult Patient ○ Parent or Guardian ○ Spouse