KRANZ CHIROPRACTIC
Whiplash & Spinal Therapy

James W. Kranz, D.C.
910 North Curtis Road
Boise, Idaho 83706
(208) 377-3777
Fax (208) 377-3779

Date: _____

Name: _____ Social Security #: _____ Home phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Email: _____ Cell phone: _____

Birth date: _____ Age: _____ Marital Status: M S W D How many children? _____

Emergency contact: _____ Phone: _____

Occupation: _____ Employer: _____ Office phone: _____

Employer's address: _____

Referred to our office by: _____ Address: _____

Previous chiropractic care? ☐ Yes ☐ No Doctor's name: _____

Spouse's name: _____ Social Security #: _____ Occupation: _____ DOB: _____

Employer: _____ Employer's address: _____

Purpose of this appointment (major complaint): _____

_____

What activities aggravate this condition? _____

Is this condition getting progressively worse? ☐ Yes ☐ No Pain: ☐ Constant ☐ Comes and goes

Is this condition interfering with your: ☐ Work ☐ Sleep ☐ Daily routine ☐ Other: _____ Days lost from work: _____

Did this condition arise from an auto accident or employment? _____ **If yes, please tell receptionist.**

Other doctors seen for this condition: _____

Date of onset: _____ Ladies, are you pregnant? ☐ Yes ☐ No

Check any of the following: ✔ If a current problem. ☑ If occurred in the past.

Current	Past		Current	Past		Current	Past		Current	Past		Current	Past	
○	☐	Allergy	○	☐	Swollen joints	○	☐	Sinus infection	○	☐	Kidney infection/ stone	Tingling or numbness in:		
○	☐	Dizziness	○	☐	Neck pain	○	☐	Pain over heart	○	☐	Prostate trouble	○	☐	Shoulders
○	☐	Fatigue	○	☐	Sciatica	○	☐	Poor circulation	○	☐	Cramps or backache	○	☐	Arms
○	☐	Headache	○	☐	Difficult digestion	○	☐	Chest pain	○	☐	Irregular cycle	○	☐	Elbows
○	☐	Loss of sleep	○	☐	Nausea	○	☐	Stroke	○	☐	Excessive flow	○	☐	Hands
○	☐	Ulcers	○	☐	Asthma	○	☐	Difficult breathing	○	☐	Diabetes	○	☐	Hips
○	☐	Nervousness	○	☐	Ear noises	○	☐	Swelling of ankles	○	☐	Difficult chewing	○	☐	Legs
○	☐	Depression	○	☐	Eye pain	○	☐	Cancer	○	☐	Blurred vision	○	☐	Knees
○	☐	Numbness	○	☐	High blood pressure	○	☐	Itching	○	☐	Ear aches	○	☐	Feet
○	☐	Arthritis	○	☐	Bruise easily	○	☐	Varicose veins						
○	☐	Bursitis				○	☐	Bed wetting						

Habits:	Heavy	Moderate	Light	None
Alcohol	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Drugs	☐	☐	☐	☐

	Heavy	Moderate	Light	None
Exercise	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Appetite	☐	☐	☐	☐

Do you take vitamins or minerals? ☐ Yes ☐ No

Do you think that you need vitamins or minerals? ☐ Yes ☐ No

Are you wearing: ☐ Heel lifts ☐ Sole lifts ☐ Inner soles ☐ Arch supports

PLEASE COMPLETE THE OTHER SIDE ➡

Are you currently taking any medications? _____

What operations have you had in the past? _____

Have you had any serious accidents? Describe: _____

Have you had any serious illnesses? Describe: _____

Name of person responsible for payment: _____

Method of payment: ☐ Cash ☐ Insurance ☐ Visa/MasterCard ☐ Other: _____

Insurance company (please give your insurance card to the receptionist to copy for your file):

Company name #1: _____ Address: _____

Group #: _____ Membership #: _____

Company name #2: _____ Address: _____

Group #: _____ Membership #: _____

Payment is expected at time of visit unless other arrangements are made.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this chiropractic office will prepare any necessary reports and forms to assist me in making collections from the insurance carrier and that any amount authorized to be paid directly to this chiropractic office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care or treatment, any fees for professional services rendered me will be immediately due and payable and that interest is charged at the rate of 1.5% per month (18% per annum) on those amounts 60 days and over. I further authorize and allow Dr. James Kranz, Associates, and his staff to perform necessary tests and to render chiropractic care.

Patient's signature: _____ Date: _____

Information taken by: _____ Date: _____