Today’s Date\_\_\_\_\_\_\_\_\_\_\_\_ Sara Klingenberg, D.C.

Mobile Chiropractor

406.212.1909

[**www.mtmobilechiro.com**](http://www.mtmobilechiro.com)

[gonsteaddr@hotmail.com](mailto:gonsteaddr@hotmail.com)

**History Form**

Please fill out this form as completely and accurately as possible. All the information requested below is private information kept between the chiropractor and patient. It can only be shared with patient consent.

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone number you can reached at:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_\_\_Zip Code\_\_\_\_\_\_\_\_\_\_\_\_

Age\_\_\_\_\_Birth Date\_\_\_\_\_\_\_\_\_Marital Status: M S W D How Many Children?\_\_\_\_\_\_

Emergency Contact Person’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship to Patient\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact Phone Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Personal Email\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been under chiropractic care? Yes\_\_\_ No\_\_\_ Doctor’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Purpose of this appointment (Major Complaint):**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**What aggravates your condition?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is this condition getting progressively worse? Yes\_\_\_ No\_\_\_\_ Constant:\_\_\_\_\_\_\_\_ Comes and Goes\_\_\_\_\_\_\_\_\_

Is this condition interfering your: Work\_\_\_\_ Sleep\_\_\_\_ Daily Routine\_\_\_\_ Other\_\_\_\_

How long has it been since you really felt good?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What do you believe is wrong with you?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other doctors seen for this condition?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you been treated for any health conditions by a physician in the last year? Yes\_\_\_\_No\_\_\_\_Describe\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have constipation issues or any digestive issues?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you taking any medications? Yes\_\_\_No\_\_\_ If so, which ones?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been any major accidents or had any major injuries?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever broken and bones or had any surgeries? If so please specify?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been diagnosed with any disease? If so please specify?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**If you are female, are you pregnant?\_\_\_\_\_\_\_\_**

Remarks and additional information you think I should know?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Financial Information**: Payment in FULL is expected on all FIRST VISIT services. All other fees are to be paid at time of service unless other arrangements have been made and agreed upon in writing. Note that **ONLY CASH** or **LOCAL CHECKS (meaning in the town you are being seen in or from Kalispell)** are accepted for payment. If you have any financial difficulties in making your payment please speak to me personally so that your health is not hindered due to financial burden. The benefit of paying cash is a lower fee due to lower overhead for me. With administrative fees making up much of an adjustment fee, it is my goal to cut cost and paperwork. In this manner I can ensure more quality time for you at an affordable rate.

*The information I have provided, on this case history form, is true and accurate, to the best of my knowledge. I give Sara Klingenberg, D.C. permission to render care to me from this day forward. This initial visit includes a health history/consultation, chiropractic exam/evaluation, and any initial care that is determined to be necessary and mutually agreed upon. By signing below I also agree that Sara Klingenberg, D.C. will not treat or diagnose any ailment but simple locate and find subluxations and adjust them so that my body can help heal itself. I understand that Sara Klingenberg, D.C. is not a participant in any medical insurance, local or federal, and all payment is between the patient and the chiropractor.*

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**X-Ray Agreement**: If Sara Klingenberg, D.C. recommends x-rays prior to an adjustment you will be referred to Flathead Orthopedic Center where x-rays are taken at a very affordable cost. If you refuse x-rays you agree that you have no fractures, breaks, congenital abnormalities or other pathologies that would contraindicate an adjustment and do not hold Sara Klingenberg, D.C. responsible for any type of injury.

Patient Signature: Print Name: Today’s Date:

**Appointment Agreement**: Sara Klingenberg, D.C. travels to different locations, often times a long distance and values her time and the time of her patients. Please be courteous and call 24hrs prior to your scheduled appointment if you need to cancel. **If you miss an appointment without calling 24 hours prior, you will be charged the cost of your adjustment.**

Patient Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s Date:\_\_\_\_\_\_\_\_\_\_\_

Have you suffered from:

Please mark each answer that applies to you with one of the two choices: **P –past**  or **C-Current**

\_\_\_Allergy \_\_\_Nausea \_\_\_Stroke \_\_\_Fatigue

\_\_\_Dizziness \_\_\_Asthma \_\_\_Chest pain \_\_\_Colds

\_\_\_Difficulty Breathing \_\_\_Headaches \_\_\_Deafness \_\_\_Pleurisy

\_\_\_Loss of Sleep \_\_\_Ear Noises \_\_\_Spitting \_\_\_Ulcers

\_\_\_Enlarged Thyroid \_\_\_Itching \_\_\_Nervousness \_\_\_Depression

\_\_\_Eye Pain \_\_\_Varicose Veins \_\_\_Numbness \_\_\_Failing Vision

\_\_\_Arthritis \_\_\_ Venereal Disease \_\_\_Frequent Urination \_\_\_Bursitis

\_\_\_Tuberculosis \_\_\_Kidney Infections/Stones \_\_\_Foot Trouble \_\_\_Bruise Easily

\_\_\_Prostate Trouble \_\_\_Low Back Pain \_\_\_Hay Fever \_\_\_Cramps/Backache

\_\_\_Neck Pain/Stiffness \_\_\_Nosebleeds \_\_\_Excessive Menstrual Flow

\_\_\_Poor Posture \_\_\_Sinus Infection \_\_\_Hot Flashes/Night Sweats

\_\_\_Sciatica \_\_\_High Blood Pressure \_\_\_Irregular Cycles \_\_\_Hemorrhoids

\_\_\_Spinal Curvatures \_\_\_Low Blood Pressure \_\_\_Lumps in Breast \_\_\_Anemia

\_\_\_Swollen/Painful Joints \_\_\_Pain Over Heart \_\_\_Alcoholism \_\_\_Cancer

\_\_\_Colon Trouble \_\_\_Poor Circulation \_\_\_Diabetes \_\_\_Polio

\_\_\_Diarrhea \_\_\_Rapid Heart beat \_\_\_Swelling in Ankles

\_\_\_Difficult Digestion \_\_\_Slow Heart beat

Tingling or Numbness in:

\_\_\_\_Shoulders \_\_\_\_Arms \_\_\_Elbows \_\_\_Hands

\_\_\_\_Buttocks \_\_\_\_Thighs \_\_\_Below Knee \_\_\_Feet

Heavy Moderate Light Never

\_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ Alcohol

\_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ Coffee

\_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ Tobacco

\_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ Drugs

\_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ Exercise

\_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ Sleep

\_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ Appetite

\_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ Stress

Do you wear: Heal lifts\_\_\_\_ Sole lifts\_\_\_\_ Inner soles\_\_\_\_ Arch supports\_\_\_\_

Do you now take vitamins or minerals? Yes\_\_\_ No\_\_\_\_

Is there anything else that you might not have already stated that you think your chiropractor should know? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If this paperwork has been filled out for a minor, please sign below as a parent or legal guardian, giving Sara Klingenberg, D.C. permission to assess and adjust your child.

Parent’s Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Printed Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Chiropractor’s Notes: