Today's Date_____

Sara Klingenberg, D.C.
Mobile Chiropractor
406.212.1909
www.mtmobilechiro.com
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: