

Sara Klingenberg, D.C.  
410 1<sup>st</sup> Ave West  
Kalispell, MT 59901  
406.212.1909  
gonsteaddr@hotmail.com

**ADULT HISTORY FORM**

Please fill out this form as completely and accurately as possible.  
All the information requested below, is necessary for us to serve you the best way possible.

Today's Date \_\_\_\_\_

Patient Account # \_\_\_\_\_

**PERSONAL DATA**

First Name \_\_\_\_\_ MI \_\_\_\_\_ Last Name \_\_\_\_\_

Age \_\_\_\_\_ Date of Birth \_\_\_\_\_ Weight \_\_\_\_\_ Height \_\_\_\_\_

Status: S M D W Name of Spouse \_\_\_\_\_

Names and Ages of Children \_\_\_\_\_

Home Address \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_ Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

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

Occupation \_\_\_\_\_

Emergency Contact Person Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

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

Whom may we thank for referring you to our office? \_\_\_\_\_

**REASON FOR SEEKING CHIROPRACTIC CARE**

What health concerns do you feel we can address for you? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Is this concern affecting your quality of life? (Please circle only those applicable to you)

Work:	Y	N	Recreation:	Y	N	Sleep:	Y	N
School:	Y	N	Walking:	Y	N	Sitting:	Y	N
Exercise/Sports:	Y	N	Eating:	Y	N	Love life:	Y	N

**HEALTH CARE PRACTITIONER HISTORY**

Have you ever received Chiropractic care before? Y N Doctor Name: \_\_\_\_\_

How long under care? \_\_\_\_\_ Date of last visit: \_\_\_\_\_ Why did you stop? \_\_\_\_\_

Was there a particular health concern for which you consulted the chiropractor? \_\_\_\_\_

\_\_\_\_\_

Patient Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_ Patient ID# \_\_\_\_\_

Have you consulted or do you regularly consult any of the following care providers? (Check all that apply)

- Medical Physician     Naturopath     Acupuncturist     Homeopath     Energy Healer  
 Massage Therapist or Physical Therapist     Psychotherapist     Other \_\_\_\_\_

Reasons why: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**FOR FEMALES**

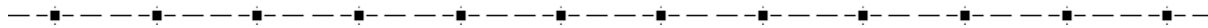
Are you pregnant?    Y    N    Date of last menstrual period: \_\_\_\_\_

If x-rays are recommended, your signature is required (below) to indicate that you are **NOT** pregnant.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If pregnant, what is your due date? \_\_\_\_\_ OBGYN/Midwife Name: \_\_\_\_\_

Where will you be birthing your baby?     Hospital     Home     Birthing Center     Other \_\_\_\_\_



**HEALTH, WELLNESS AND CHIROPRACTIC CARE**

The human body has the innate ability to heal itself and restore health. The primary system in the body which coordinates health is the NERVE SYSTEM. The vertebrae (bones of the spine) surround and protect the delicate NERVE SYSTEM. Being the fact that the nervous system controls all functions of the body, it is important to be subluxation free so that your nervous system functions as optimally as possible.

Physical, emotional and chemical stresses, common to our contemporary lifestyles, can result in misalignment to the spinal column as well as damage to the nerve system. The result is a condition called Vertebral Subluxation Complex, which we simply call a **SUBLUXATION**. A subluxation is simply a bone out of position causing nerve interference or impingement. The Chiropractic Examination determines if your spine shows signs of the Vertebral Subluxation process, which can lead to a weakened immune system.



Please review and indicate your history of “stresses” below so that we can assess their relationship to your present health status and examination findings. We will discuss this during your consultation.

**HISTORY OF PHYSICAL STRESSES (Birth to Present)**

The **birth process** can traumatize a **baby's spine** and cause **damage to the nerve system**. Please indicate to the best of your knowledge where and how you were birthed (Check all that apply). If you do not know, please skip to next question.

- Home     Natural     Hospital     Caesarian Section     Forceps  
 Breech     Cord around Neck     Prolonged Labor     Drug Induced Labor     Suction

**Patient Name:** \_\_\_\_\_ **Today's Date:** \_\_\_\_\_ **Patient ID#** \_\_\_\_\_

The information below will help us to see the types of **PHYSICAL** stresses that you have been subjected to and how they may relate to your present health status.

• Have you had any accidents related to any of the following? (Check all that apply)

- Automobile     Motorcycle/Bicycle     Abuse     Sport     Playground     Other

If yes, please explain how and dates: \_\_\_\_\_

• Have you ever injured your spine (head, neck, rib/chest area, back, pelvis or hips)?    Y    N

If yes, please explain how and dates: \_\_\_\_\_

• Have you ever broken any bones or sprained any part of your body?    Y    N

If yes, please explain how and dates: \_\_\_\_\_

• Have you ever been hospitalized?    Y    N

If yes, please explain how and dates: \_\_\_\_\_

### ***HISTORY OF CHEMICAL STRESSES***

**CHEMICAL** stresses occur during life due to **any substance** that is breathed, injected, taken by mouth, or placed on the skin that is toxic to the body, (e.g.: food allergies, drug reactions, exposure to chemicals in the air, etc.). The following will give us insight into any exposures you may have had.

• Have you ever been vaccinated?    Y    N    If yes, did you have a reaction from it?    Y    N

• Have you been exposed to any of the following on a regular basis (past or present)?

- Toxic Chemicals     Drugs (prescribed or not)     Second Hand Smoke     Other \_\_\_\_\_

If yes, please explain: \_\_\_\_\_

• Do you have allergies to any foods?    Y    N    If yes, please: \_\_\_\_\_

• Do you consume any of the following presently?

- Coffee/Caffeine     Alcohol     Tobacco     Over the Counter Drugs     Prescribed Drugs

Please list all medications (prescribed and over the counter): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**NOTE:** It is imperative that you list all medications as they may have an influence on your care.

Patient Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_ Patient ID# \_\_\_\_\_

**HISTORY OF EMOTIONAL STRESSES**

It is difficult to separate the **EMOTIONAL** stress in our life from the physical response that often occurs. Please indicate if you have experienced any of the emotional stresses below:

Childhood Trauma	Y	N	Loss of loved one	Y	N	Abuse	Y	N
Work or School	Y	N	Divorce/Separation	Y	N	Financial	Y	N
Lifestyle Change	Y	N	Parents Divorce	Y	N	Illness	Y	N

**QUALITY OF LIFE**

- How do you grade your physical health?       Good       Fair       Poor
- How do you grade your emotional/mental health?       Good       Fair       Poor
- How do you rate your overall "quality of life"?       Good       Fair       Poor

**EXPECTATIONS**

As a result of my Chiropractic Care, I would like to (Check all that apply):

- Feel Better Quickly       Have a Healthier Nerve System
- Have a Healthier Spine       Have Optimum Health on all Levels

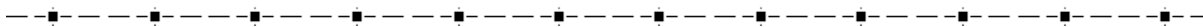
**FINANCIAL INFORMATION**

**Private Pay** - 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 is 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.

**Note that if you have insurance** I can give you a receipt for your care and you can send in a claims form with the bill and deal with getting reimbursed from your insurance.

*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 clinically necessary and mutually agreed upon. By signing below I also agree that Sara Klingenberg, D.C. will not treat nor diagnose any ailment but simply 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: \_\_\_\_\_



**Thank you for choosing Sara Klingenberg, D.C. as your chiropractor.**

Patient Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_ Patient ID# \_\_\_\_\_

*I look forward in helping your body help heal itself.*

**HEALTH HISTORY CHECKLIST**

Do you currently have or have you previously had any of the following symptoms?

<b>General</b>	<b>Present</b>	<b>Past</b>	<b>Circulatory</b>	<b>Present</b>	<b>Past</b>	<b>Genital-Urinary</b>	<b>Present</b>	<b>Past</b>
Allergy	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Press	<input type="checkbox"/>	<input type="checkbox"/>	Bed-wetting	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness/Faint	<input type="checkbox"/>	<input type="checkbox"/>	Low Blood Press	<input type="checkbox"/>	<input type="checkbox"/>	Frequent urination	<input type="checkbox"/>	<input type="checkbox"/>
Headache	<input type="checkbox"/>	<input type="checkbox"/>	Poor Circulation	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Infection/ Stones	<input type="checkbox"/>	<input type="checkbox"/>
Numbness	<input type="checkbox"/>	<input type="checkbox"/>	Rapid Heart Beat	<input type="checkbox"/>	<input type="checkbox"/>	Painful Urination	<input type="checkbox"/>	<input type="checkbox"/>
			Slow Heart Beat	<input type="checkbox"/>	<input type="checkbox"/>	Prostate Trouble	<input type="checkbox"/>	<input type="checkbox"/>
<b>Gastro-Intestinal</b>			<b>Respiratory</b>			<b>FEMALES ONLY</b>		
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Number of Children	_____	
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Previous Miscarriages	_____	
Difficulty Digest	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	Painful Menses	Yes	No
Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Breathing	<input type="checkbox"/>	<input type="checkbox"/>	Irregular Cycle	Yes	No
<b>Eyes, Ears, Nose &amp; Throat</b>			<b>Other</b>			Date of Last Cycle	_____	
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Flow	Yes	No
Deafness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2			Menopausal	Yes	No
Earache	<input type="checkbox"/>	<input type="checkbox"/>	High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>			
Sinus Infection	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>			
<b>Cardio-Vascular</b>			Anemia	<input type="checkbox"/>	<input type="checkbox"/>			
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Carpal Tunnel	<input type="checkbox"/>	<input type="checkbox"/>			
Hardening Arteries	<input type="checkbox"/>	<input type="checkbox"/>	Obesity	<input type="checkbox"/>	<input type="checkbox"/>			

On a scale of 1 through 10, please rate your level of commitment to a healthy lifestyle:

1            2            3            4            5            6            7            8            9            10

- ❖ Describe the quality of your sleep:  Poor  Fair  Good  Excellent
- ❖ How many hours do you sleep? \_\_\_\_\_
- ❖ Do you sleep on your side / back / stomach? Circle all that apply
- ❖ Do you drink water? \_\_\_\_\_ Glass(es)/day
- ❖ Do you drink soda/pop? No Yes \_\_\_\_\_ Can(s)/day
- ❖ Do you drink alcohol? No Yes Drink(s)/week \_\_\_\_\_
- ❖ Do you drink coffee or tea? No Yes \_\_\_\_\_ Cup(s)/day
- ❖ Do you ever eat fast food, if so how often? \_\_\_\_\_
- ❖ Do you smoke? No Yes \_\_\_\_\_ Cig(s)/day
- ❖ Do you take vitamins? No Yes  Daily  When you remember
- ❖ Do you grind or clench your teeth? No Yes
- ❖ In an average day, how many hours do you sit? \_\_\_\_\_

NOTES

---



---



---

**Patient Name:** \_\_\_\_\_ **Today's Date:** \_\_\_\_\_ **Patient ID#** \_\_\_\_\_

---

---

**Patient Name:** \_\_\_\_\_ **Today's Date:** \_\_\_\_\_ **Patient ID#** \_\_\_\_\_