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PEDIATRIC HISTORY FORM

(17 years old and under)

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 _____ Male Female

Birth Weight: _____ Birth Height: _____ Current Weight: _____ Current Height: _____

Home Address _____ City _____

State _____ Zip _____ Home Phone _____ Cell Phone _____

Emergency Contact Person Name _____ Relationship to Patient _____

Emergency Contact Phone Number _____ Email _____

Whom may we thank for referring you to our office? _____

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 **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.

REASON FOR SEEKING CHIROPRACTIC CARE

What health concerns do you feel we can address for you today? _____

Does your child currently have or have they previously had any of the following symptoms:

- | | | |
|--------------------------------------|-------------------------------------|--------------------------------------|
| <input type="checkbox"/> Acid Reflux | <input type="checkbox"/> Asthma | <input type="checkbox"/> Cold Feet |
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Bedwetting | <input type="checkbox"/> Cold Hands |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Cold Sweats |

Patient Name: _____ **Today's Date:** _____ **Patient ID#** _____

- | | | |
|------------------------------------------------|----------------------------------------------------|--------------------------------------------------|
| <input type="checkbox"/> Colic | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Ringing/Buzzing in Ears |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Frequent Fever | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Headaches | <input type="checkbox"/> Sleeping Problems |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Irritability | <input type="checkbox"/> Tension |
| <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Light Sensitivity to Eyes | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Excessive spitting up | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Upset Stomach |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Urinary Problems |

HEALTH CARE PRACTITIONER HISTORY

Has the child 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? _____

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

- Medical Physician Naturopath Acupuncturist Homeopath Energy healer
 Massage Therapist or Physical Therapist Psychotherapist Other _____

Reasons why: _____

Name of: OB/GYN: _____ Date of Last Visit: _____
 Midwife: _____ Date of Last Visit: _____
 Family M.D.: _____ Date of Last Visit: _____

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)

Delivery: *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 the child was birthed (Check all that apply).*

- Home Birthing Center Hospital Vaginal Caesarian Section Forceps
 Breech Cord around Neck Prolonged Labor Drug Induced Labor Suction

Any problems during pregnancy and/or labor? (If you need more space, please write on the back) _____

Infant Feeding:

- Breast (Until age of): _____ Formula (Until age of): _____
 Direct Suckle Bottled Finger Sucking Pacifiers

Patient Name: _____ **Today's Date:** _____ **Patient ID#** _____
Sleeping Hrs Daily: _____ **Quality of Sleep:** Good Fair Poor
APGAR score: _____ At birth, presence of Jaundice (Yellow) Cyanosis (Blue)
 Any Congenital Anomalies/Defects: _____

Developmental History (Age of the Child When Occurred):

Respond to Sound _____	Stand _____	Rubella _____
Follow an Object with Eyes _____	Walk Alone _____	Rubeola _____
Hold Head Up _____	Chicken Pox _____	Whooping Cough _____
Crawl _____	Measles _____	
Sit Alone _____	Mumps _____	
Other _____		

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

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

- Automobile
 Motorcycle
 Bicycle
 Sports
 Playground
 Abuse

If yes, please explain how and dates: _____

Has your child ever injured his/her spine (head, neck, rib/chest area, back, pelvis or hips)? Y N

If yes, please explain how and dates: _____

Has your child ever broken any bones or sprained any part of the body? Y N

If yes, please explain how and dates: _____

Has your child 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.*

Has your child been ever vaccinated? Y N If yes, did she/he have a reaction from it? Y N

Has your child 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: _____

Patient Name: _____ Today's Date: _____ Patient ID# _____

Does she/he have allergies to any foods? Y N If yes, please: _____

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 the care:* _____

HISTORY OF EMOTIONAL STRESSES

It is difficult to separate the **EMOTIONAL STRESSES** 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 his/her physical health? Good Fair Poor
- How do you grade his/her emotional/mental health? Good Fair Poor
- How do you rate his/her overall "quality of life"? Good Fair Poor

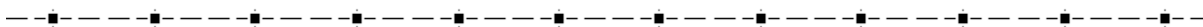
FINANCIAL INFORMATION

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.

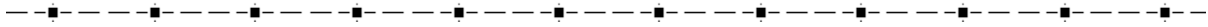
Patient Signature: _____ Print Name: _____ Today's Date: _____



Patient Name: _____ Today's Date: _____ Patient ID# _____

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

I look forward in helping you help heal yourself.



AUTHORIZATION FOR CARE OF MINOR

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 my child 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.

I hereby authorize this office and its doctor(s) to administer care as they so deem necessary to my son/daughter/ward (upon approval of parent or guardian).

Signature of Parent/Guardian: _____ Today's Date: _____

Mother's Name: _____ Father Name: _____

Mother's Phone No: _____ Father's Phone No: _____

Patient Name: _____ Today's Date: _____ Patient ID# _____

HEALTH HISTORY CHECKLIST

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

General	Present	Past	Circulatory	Present	Past	Genito-Urinary	Present	Past
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"/>
Gastro-Intestinal			Respiratory			FEMALES ONLY		
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
Eyes, Ears, Nose & Throat			Other			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"/>			
Cardio-Vascular			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? _____ Drink(s)/week
- ❖ Do you drink coffee or tea? No Yes _____ Cup(s)/day
- ❖ How many times do you eat fast food each week? _____
- ❖ Do you smoke? No Yes _____ Cig(s)/day
- ❖ Do you take vitamins? Daily When you remember
- ❖ Do you grind or clench your teeth? No Yes
- ❖ In an average day, how many hours do you sit? _____

NOTES
