

Welcome to the Office of Dr. Kate Klemer, DC

Please print clearly to help avoid billing errors

Patient Last Name First

Mailing Address Apt or Unit #

City State, Zip

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Home Telephone Cell Number Work Telephone e-mail

Date of Birth Age Social Security #

Emergency Contact Name / Relationship Phone Address

Marital Status: Single / Married / Divorced / Other Sex: Male / Female Referred By: _____

Employment Status: Employed Full Time Employed Part Time Full Time Student Unemployed Retired

Have you had Chiropractic treatment in the past? Yes / No Is this health condition auto or work related? Yes / No

*****Below for Office Only*****

DIAGS: (1) _____ (2) _____ (3) _____ (4) _____

INITIAL VISIT PROCEDURES

Date of Service: _____ Amt Paid This Visit: \$ _____ Pt. Class: Ins Cash Auto WC

New Exam Level: 1 2 3 4 5 9894 _____ 97110 97140

Manip. Thera. Ex. Man. Therapy

Check Box to Block Pt. Statements

Charge Co-Pay Only

Dr Kate Klemer Payment Policy/Practice Info

Insurance Patient's: *initial here that you read this:* _____

- I accept United, Oxford, Aetna, Harvard Pilgrim, Health New England, GIC, BCBS and others. Each policy will be checked as they are all different. You will be responsible for your co-pay, co-insurance, and deductible at each visit. Verifying coverage does not guarantee that you are covered by insurance. We do our best to find out what your coverage is, and sometimes they give us inaccurate information.
Craniosacral Therapy and Nutritional Care are not covered by any insurance
- You will be charged for unpaid insurance visits through the card on file if you have not done your part in getting us the proper insurance information, or if your insurance requires a referral from a MD prior to your app., and you did not provide that.
- In cases where you have paid up front and want us to **retroactively** bill, we will not do that. We will give you a bill, and you can submit the charges yourself.

For Health New England Policyholders: *initial here that you read this:* _____

- HNE has recently changed how they reimburse for chiropractic services. They will only cover certain types of treatment, and do not cover craniosacral therapy, or nutrition at all. For best results I use codes for therapies they do not cover. Because the code is not covered and isn't billable, the charge for 30 minute appointments is your co-pay plus \$25.00. For one hour patient and first new patient visit appointments your co-pay plus \$40.00 will apply.

Non-insurance patients:

- Must pay their visit at the time of service

LATE CANCELLATION / NO SHOW: *please initial that you read this:* _____

- You will be charged for the time allotted if you do not give 24 hours notice of cancellation, or request to shorten your appointment time on the same day.
- We require a credit card number to secure your first appointment, and it will be charged in cases of late cancels or no shows. We cannot charge your insurance for visits you do not show up for.
- You will be charged for unpaid insurance visits through this card if you have not done your part in getting us the proper insurance information, or if your insurance requires a referral from an MD prior to your appointment., and you did not provide that.
- All auto accident, insurance, self pay and workers compensation patients are required to abide by this 24-hour policy, insurance will not pay for missed appointments.

Signed: _____ Date: _____

Dr. Klemer: _____ Date: _____

HEALTH QUESTIONNAIRE – Dr. Kate Klemer

Name _____ Date _____ Age _____ Ht _____ Wt _____

Family Medical History

- Allergies (Specify) Arteriosclerosis Cancer (Specify) Diabetes Seizures
Asthma Heart Disease Stroke
Alcoholism High Blood Pressure Mental Illness

Your Past Medical History

(Check any of the following conditions you currently have/ had in the past, or you feel are a significant part of your medical history.)

- Aids/HIV Diabetes Hernia Mumps Tuberculosis
Alcoholism Eating Disorder Herniated Disc Osteoporosis Typhoid Fever
Allergies Emotional Trauma High Blood Pressure Pacemaker Ulcers
Appendicitis Emphysema Kidney Disease Pleurisy Venereal Disease
Arteriosclerosis Epilepsy Knocked Unconscious Pneumonia Whooping Cough
Arthritis Fracture Measles Polio Other (Specify)
Asthma Glaucoma Mental Illness Rheumatic Fever
Birth Trauma Goiter Migraines Scarlet Fever
Cancer Gout Miscarriage Seizures
Caesarian Heart Disease Mono Stroke
Chicken Pox Hepatitis Multiple Sclerosis Thyroid Disorder

Your Diet

- Appetite: Low High Coffee Soft Drinks Artificial Sweetener Sugar Salty Food Thirst for water: # glasses/day

Average Daily Menu:

Table with 6 columns: Morning, Snack, Noon, Snack, Evening, Snack. Each column has three blank lines for input.

Pharmaceuticals taken in last 2 months: _____

Vitamins/Supplements taken in last 2 months: _____

Blood Type: O A AB B Other _____

Orthotics: Heel Lifts Arch Supports Sole Lifts Other _____

Your Lifestyle

- Alcohol Marijuana Stress Regular Exercise (Type and Frequency)
Tobacco Drugs Occupational Hazards

Spiritual Practice _____ Fun/Hobby _____

Mattress / Futon How much sleep/night? _____ How much sleep do you like to get? _____

General Symptoms

- Poor Appetite Poor sleep Bodily heaviness Chills Bleed/bruise
Heavy Appetite Heavy sleep Cold hands or feet Night sweats Peculiar taste:
Strongly like cold drinks Dream disturbed sleep Poor circulation Sweat easily
Strongly like hot drinks Fatigue Shortness of breath Muscle cramps
Recent weight loss/gain Lack of strength Fever Vertigo or dizziness

Head, Eyes, Ears, Nose, Throat

- Glasses
- Eye Strain
- Eye Pain
- Red Eyes
- Itchy Eyes)
- Spots in Eyes
- Poor Vision
- Blurred Vision
- Night Blindness
- Glaucoma
- Cataracts
- Teeth Problems
- Grinding Teeth
- TMJ
- Facial Pain
- Gum Problems
- Sores on Mouth/Lips
- Dry Mouth
- Excessive Saliva
- Sinus Problems
- Excessive Phlegm
- Color of phlegm:**

- Recurrent Sore Throat
- Swollen Glands
- Lumps in Throat
- Enlarged Thyroid
- Nose Bleeds
- Ringing in Ears
- Poor Hearing
- Earaches
- Headaches
- Migraines
- Concussions
- Other Head/Neck

- _____
- _____

Respiratory

- Difficulty breathing when lying down
- Shortness of breath
- Tight chest
- Asthma/wheezing
- Cough
Wet / Dry?
Thick / thin?
- Color of phlegm:**

- Coughing Blood
- Pneumonia

Cardiovascular

- High blood pressure
- Blood clots
- Low blood pressure
- Fainting
- Chest Pain
- Difficulty breathing
- Tachycardia
- Heart palpitations
- Phlebitis
- Irregular heartbeat

Musculoskeletal

- Neck/shoulder pain
- Muscle pain
- Upper back pain
- Low back pain
- Joint Pain
- Rib Pain
- Limited range of motion
- Limited use of: _____

Skin and Hair

- Rashes
- Hives
- Ulcerations
- Eczema
- Psoriasis
- Acne
- Dandruff
- Itching
- Change in texture
- Fungal infections
- Hair loss
- Other

Neuropsychological

- Seizures
- Numbness
- Tics
- Poor memory
- Depression
- Anxiety
- Irritability
- Easily stressed
- Abuse survivor
- Considered/Attempted Suicide
- Seeing a therapist
- Other _____

Genito-urinary

- Pain on urination
- Frequent urination
- Urgent urination
- Blood in urine
- Unable to hold urine
- Incomplete urination
- Venereal Disease
- Bedwetting
- Wake to urinate
- Increased libido
- Decreased libido
- Kidney stone
- Impotence
- PreEjaculation
- NocEmission

Gynecology

- Age menses began _____
- Length of cycle _____
- Duration of flow _____
- Date of last PAP _____
- Irregular Periods
- Painful periods
- Painful periods
- Date last period began _____
- PMS
- Vaginal discharge
color: _____
- Vaginal odor
- Vaginal sores
- Clots
- Breast lumps
- # of live births _____
- Premature births _____
- Age at menopause _____
- # of pregnancies _____

Surgery (with approximate date):

- _____
- _____

Major Trauma (list any falls, car accidents or other major trauma with approximate date of incident):

- _____
- _____

Date of Last: Physical _____ Blood Test _____ Chest Xray _____ Spine Xray _____
 CT Scan _____ Urine Test _____ MRI _____ Bone Density _____

The information I have given is accurate and I have read the Health Questionnaire entirely. _____ Date _____

Patient Signature

Liver / Gallbladder:

- Dizziness
- Dry Skin
- Burning Feet
- Blurred Vision
- Itching Skin and Feet
- Excessive Falling Hair
- Frequent Skin Rashes
- Bitter, metallic taste in mouth in mornings
- Bowel movements painful or difficult
- Burning or itching anus
- Worrier, feels insecure
- Feeling queasy; headache over eyes
- Greasy foods upset
- Stools light-colored
- Skin peels on foot soles
- Pain b/w shoulder blades
- Use laxatives
- Stools alternate from soft to watery
- History of gallbladder attacks or gallstones
- Sneezing attacks
- Dreaming, nightmare type bad dreams
- Bad breath
- Milk products cause distress
- Sensitive to hot weather
- Craving sweets

Digestion:

- Loss of taste for meat
- Lower bowel gas several hours after eating
- Burning stomach sensation, eating relieves
- Coated tongue
- Pass large amounts of foul-smelling gas
- Indigestion $\frac{1}{2}$ - 1 hour after eating; may be up to 3-4 hours
- Mucous colitis or "irritable bowel"
- Gas shortly after eating
- Stomach "bloating" after eating