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**

_(________)

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:________________

Please provide Dr. Klemer with the following information:

Credit Card Number:____

Expiration Date:____

CV#:_________________

Your zip code:____________________

HEALTH QUESTIONNAIRE – Dr. Kate Klemer

Name____ **Date**________________ **Age**______ **Ht**______ **Wt**______

Family Medical History

☐ Allergies (Specify)
____
____

☐ Arteriosclerosis
☐ Asthma
☐ Alcoholism

☐ Cancer (Specify)
____
____

☐ Diabetes
☐ Heart Disease
☐ High Blood Pressure

☐ Seizures
☐ Stroke
☐ 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
☐ Alcoholism
☐ Allergies
☐ Appendicitis
☐ Arteriosclerosis
☐ Arthritis
☐ Asthma
☐ Birth Trauma
☐ Cancer
☐ Caesarian
☐ Chicken Pox

☐ Diabetes
☐ Eating Disorder
☐ Emotional Trauma
☐ Emphysema
☐ Epilepsy
☐ Fracture
☐ Glaucoma
☐ Goiter
☐ Gout
☐ Heart Disease
☐ Hepatitis

☐ Hernia
☐ Herniated Disc
☐ High Blood Pressure
☐ Kidney Disease
☐ Knocked Unconscious
☐ Measles
☐ Mental Illness
☐ Migraines
☐ Miscarriage
☐ Mono
☐ Multiple Sclerosis

☐ Mumps
☐ Osteoporosis
☐ Pacemaker
☐ Pleurisy
☐ Pneumonia
☐ Polio
☐ Rheumatic Fever
☐ Scarlet Fever
☐ Seizures
☐ Stroke
☐ Thyroid Disorder

☐Tuberculosis
☐ Typhoid Fever
☐ Ulcers
☐ Venereal Disease
☐ Whooping Cough
☐ Other (Specify)
☐ ___________________
☐ ___________________
☐ ___________________

Your Diet

Appetite: ☐ Low ☐ High

☐ Coffee ☐ Soft Drinks

☐ Artificial Sweetener

☐ Sugar ☐ Salty Food

☐ **Thirst for water:** _____**# glasses/day**

Average Daily Menu:

Morning	Snack	Noon	Snack	Evening	Snack
______________	________	______________	________	______________	________
______________	________	______________	________	______________	________
______________	________	______________	________	______________	________

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
☐ Tobacco

☐ Marijuana
☐ Drugs

☐ Stress
☐ Occupational Hazards

☐ Regular Exercise (Type and Frequency)
____

Spiritual Practice__________________________ **Fun/Hobby**______________________________________

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

General Symptons

☐ Poor Appetite
☐ Heavy Appetite
☐ Strongly like cold drinks
☐ Strongly like hot drinks
☐ Recent weight loss/gain

☐ Poor sleep
☐ Heavy sleep
☐ Dream disturbed sleep
☐ Fatigue
☐ Lack of strength

☐ Bodily heaviness
☐ Cold hands or feet
☐ Poor circulation
☐ Shortness of breath
☐ Fever

☐ Chills
☐ Night sweats
☐ Sweat easily
☐ Muscle cramps
☐ Vertigo or dizziness

☐ Bleed/bruise
☐ Peculiar taste:
____

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 ½ - 1 hour after eating; may be up to 3-4 hours
- Mucous colitis or “irritable bowel”
- Gas shortly after eating
- Stomach “bloating” after eating