



December 2011

Hello and welcome!

I'm writing to let you know my philosophy of health care and how I work.

First Visit:

My practice is holistic and unusual in that I treat your whole body using Chiropractic, Nutrition, and Craniosacral Therapy (a form of mind-body medicine). Treatment is based on the goals that you have. Please do not hesitate to explain to me what your goals are for better health. After an extensive history and exam I will create a personalized program based that will be the fastest way for you to reach your goals. It will be important for you to make every effort to follow through with the treatment program I have designed especially for you.

Appointments:

Your appointment time is reserved especially for you, and I respect your time. If you are running late, remember that I cannot extend your appointment, as that will take time away from the next patient. If you need to cancel please give us 24 hour notice, or else you will be charged.

Payment:

- For self-paying/non-insurance patients payment is expected at the time of each visit. Your first new patient visit is an hour and costs \$180
- For patients that have United, Oxford, or Aetna insurances, I will accept payment from your insurance for Chiropractic. We will make every effort to verify your coverage before you arrive. If you are concerned about your coverage, I would advise you to check it yourself as well. You are responsible for your co-pays, co-insurance, and deductibles at the time of each visit.
- I accept Visa, M/C, Amex, Cash, Money Orders, and Checks



Supplements:

I can order supplements for you and give you a discounted rate. They will be shipped directly to you. To refill your order please contact me via e-mail at: drkateklemer@gmail.com

Scheduling:

I offer two scheduling options for your convenience: You can go directly to my website and click the “**book an appointment online**” box in the right hand column. Or you can follow the GENBOOK link in the e-mail reminders.

If you prefer calling, call DR KATE at 888-375-2835 and schedule with my answering 24/7 service. Please do not schedule through my e-mail or phone as I am with patients.

Contact:

The best way to contact me with medical/health questions is by e-mail: at drkateklemer@gmail.com

I will make every effort to get back to you within 24 hours. If it takes longer it is because I am away teaching or an emergency came up. If it is urgent you can call 888 375-2835 and press extension 1 which is my direct line.



Some important things to note:

Your First Visit please bring:

- your completed health questionnaire
- your completed new patient info form
- medical info: RX, former diagnosis, x-rays, CT/MRI reports, supplements taking
- any questions you would like to ask including your goals
- if you have insurance I will need your card to copy it
- phone numbers and names of other practitioners you would like me to communicate with.

Best Wishes to your new start towards better health!

Dr. Kate

HEALTH QUESTIONNAIRE – Dr. Kate Klemer

Name _____ Date _____ Age _____ Ht _____ Wt _____

Family Medical History

- | | | | | |
|---|---|--|--|---|
| <input type="checkbox"/> Allergies (Specify)
_____ | <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Cancer (Specify)
_____ | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Seizures |
| _____ | <input type="checkbox"/> Asthma | _____ | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Stroke |
| _____ | <input type="checkbox"/> Alcoholism | _____ | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> 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.)

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

Your Diet

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

- | | | | |
|----------------------------------|------------------------------------|---|--|
| <input type="checkbox"/> Alcohol | <input type="checkbox"/> Marijuana | <input type="checkbox"/> Stress | <input type="checkbox"/> Regular Exercise (Type and Frequency) |
| <input type="checkbox"/> Tobacco | <input type="checkbox"/> Drugs | <input type="checkbox"/> Occupational Hazards | _____ |

Spiritual Practice _____ Fun/Hobby _____

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

General Symptoms

- | | | | | |
|--|--|--|---|---|
| <input type="checkbox"/> Poor Appetite | <input type="checkbox"/> Poor sleep | <input type="checkbox"/> Bodily heaviness | <input type="checkbox"/> Chills | <input type="checkbox"/> Bleed/bruise |
| <input type="checkbox"/> Heavy Appetite | <input type="checkbox"/> Heavy sleep | <input type="checkbox"/> Cold hands or feet | <input type="checkbox"/> Night sweats | <input type="checkbox"/> Peculiar taste:
_____ |
| <input type="checkbox"/> Strongly like cold drinks | <input type="checkbox"/> Dream disturbed sleep | <input type="checkbox"/> Poor circulation | <input type="checkbox"/> Sweat easily | |
| <input type="checkbox"/> Strongly like hot drinks | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Muscle cramps | |
| <input type="checkbox"/> Recent weight loss/gain | <input type="checkbox"/> Lack of strength | <input type="checkbox"/> Fever | <input type="checkbox"/> 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