**CHILD’S NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MOTHER’S NAME:**

**LAST FIRST MIDDLE LAST FIRST FATHER’S NAME: ­­­­­­­­­­­­­­­­­­­­­­­­­­­**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**LAST FIRST**

**ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CITY/TOWN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ STATE: \_\_\_\_\_ ZIP:**

**HOME PHONE: \_\_\_\_\_\_\_\_\_\_\_\_ MOTHER’S CELL PHONE: \_\_\_\_\_\_\_\_\_\_\_\_ FATHER’S CELL PHONE:**

**BIRTH DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_ AGE: \_\_\_\_ BIRTH WEIGHT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CURRENT WEIGHT:**

**SEX: \_\_\_\_\_\_\_\_\_ NO. OF SIBLINGS: \_\_\_\_\_\_\_\_\_\_ BIRTH LENGTH: \_\_\_\_\_\_\_\_\_\_ CURRENT LENGTH:**

**TYPE OF BIRTH: NORMAL VAGINAL \_\_\_\_\_ FORCEPS \_\_\_\_\_ VACCUM EXTRACTION \_\_\_\_\_**

**BREECH \_\_\_\_\_\_ CESAREAN HOME: \_\_\_\_\_\_ BIRTHING CENTER: \_\_\_\_\_ HOSPITAL: \_\_\_\_\_\_**

**WAS THERE PRESENCE AT BIRTH OF: \_\_\_\_\_ JAUNDICE (YELLOW) \_\_\_\_\_ CYANOSIS (BLUE)**

**CONGENITAL ANOMALIES/DEFECTS:**

**PURPOSE OF THIS APPOINTMENT:**

**INFANT FEEDING: BREAST \_\_\_\_\_\_\_\_\_\_ BOTTLE \_\_\_\_\_\_\_\_\_\_ FORMULA: \_\_\_\_\_\_\_\_\_\_\_**

**NO. OF HOURS OF SLEEP PER NIGHT: \_\_\_\_\_\_\_\_ QUALITY OF SLEEP: GOOD \_\_\_\_\_ FAIR \_\_\_\_\_ POOR**

**OBSTETRICIAN/MIDWIFE:**

**NAME LOCATED AT**

**PEDIATRICIAN/FAMILY MD:**

**NAME LOCATED AT**

**DATE OF LAST VISIT TO MD: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PURPOSE:**

**IMMUNIZATION HISTORY: NORMAL DELAYED NONE**

**HAS YOUR CHILD BEEN TREATED ON AN EMERGENCY BASIS?:**

**DESCRIBE:**

**AUTHORIZATION FOR CARE OF MINOR**

**I HEREBY AUTHORIZE KRUSE CHIROPRACTIC, LLC. AND IT’S DOCTOR(S) TO PROVIDE CARE AS THEY SO DEEM NECESSARY TO MY SON/DAUGHTER/WARD.**

**I REALIZE THAT I AM RESPONSIBLE FOR ALL FEES CHARGED BY THIS OFFICE AND THAT I WILL PAY FOR ALL SERVICES AS THEY ARE PERFORMED.**

**SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE:**

**WITNESSED: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE:**

**PEDIATRIC CASE HISTORY**

**PREGNANCY HISTORY:**

**DELIVERY/BIRTH HISTORY:**

**DEVELOPMENTAL HISTORY: AT WHAT AGE DID THE CHILD…**

**\_\_\_\_\_\_\_\_\_\_\_\_ RESPOND TO SOUND \_\_\_\_\_\_\_\_\_\_\_\_ CRAWL**

**\_\_\_\_\_\_\_\_\_\_\_\_ FOLLOW AN OBJECT WITH HIS/HER EYES \_\_\_\_\_\_\_\_\_\_\_\_ STAND**

**\_\_\_\_\_\_\_\_\_\_\_\_ HOLD HEAD UP \_\_\_\_\_\_\_\_\_\_\_\_ WALK ALONE**

**\_\_\_\_\_\_\_\_\_\_\_\_ SIT ALONE**

**CHILDHOOD DISEASES: \_\_\_\_\_\_\_\_\_\_\_\_ CHICKENPOX \_\_\_\_\_\_\_\_\_\_\_\_ RUBELLA**

**\_\_\_\_\_\_\_\_\_\_\_\_ MUMPS \_\_\_\_\_\_\_\_\_\_\_\_ RUBEOLA**

**\_\_\_\_\_\_\_\_\_\_\_\_ MEASLES \_\_\_\_\_\_\_\_\_\_\_\_ WHOOPING COUGH**

**OTHER:**

**HAS THIS CHILD EVER SUFFERED FROM:**

⬜ **Dizziness** ⬜ **Backaches** ⬜ **Heart Trouble** ⬜ **Chronic Earaches**

⬜ **Diabetes** ⬜ **Tuberculosis** ⬜ **Hypertension** ⬜ **Colds/Flu**

⬜ **Arthritis** ⬜ **Headaches** ⬜ **Asthma** ⬜ **Allergies**

⬜ **Neuritis** ⬜ **Digestive Disorders** ⬜ **Sinus Trouble** ⬜ **Constipation**

⬜ **Anemia** ⬜ **Rheumatic Fever** ⬜ **Orthopedic Problems** ⬜ **Diarrhea**

⬜ **Poor Appetite** ⬜ **Hyperactivity** ⬜ **Sugar Concentration** ⬜ **Behavioral Problems**

⬜ **Bed Wetting** ⬜ **Convulsions** ⬜ **Paralysis** ⬜ **Muscle Jerking**

⬜ **Fainting** ⬜ **Walking Problems** ⬜ **Broken Bones** ⬜ **Ruptures/Hernias**

⬜ **Neck Problems** ⬜ **Arm Problems** ⬜ **Leg Problems** ⬜ **“Growing Pains”**

⬜ **Joint Problems**

**PRESENT HISTORY:**

**SURGERY:**

**MEDICATIONS:**

**ACCIDENTS:**

**FAMILY HISTORY:**