

**KRUSE CHIROPRACTIC**  
5410 Page Road, Ste. 3  
Durham, NC 27703  
919-773-4967 – FAX: 919-773-4968

Date: \_\_\_\_\_

## Confidential Pediatric Questionnaire

Please complete this form as accurately as possible. Your answers will help us to determine whether chiropractic can help your child. Thank you for your cooperation.

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Birthday: \_\_\_\_\_  
Mother's Full Name: \_\_\_\_\_ Father's Full Name: \_\_\_\_\_  
Address: \_\_\_\_\_ City or Town: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Telephone # (Home): \_\_\_\_\_ (Work) \_\_\_\_\_ Social Security: \_\_\_\_\_  
 MALE  FEMALE Referred By: \_\_\_\_\_ E-mail Address: \_\_\_\_\_  
Number of Siblings: \_\_\_\_\_ Names: \_\_\_\_\_  
By what name would you like to be addressed in our office: \_\_\_\_\_  
Do you have Group Insurance?  YES  NO Company: \_\_\_\_\_  
Purpose of this Appointment? \_\_\_\_\_

### Birth Questions

Birth Weight \_\_\_\_\_ Birth Length \_\_\_\_\_

Type of Birth:  Normal Vaginal

Forceps

Breech

Cesarean

Vacuum Extraction

Place of Birth:  Home

Birthing Center

Hospital

Problems during Pregnancy \_\_\_\_\_

Problems during Labor/ Delivery \_\_\_\_\_

Apgar Scores \_\_\_\_\_ (High 8-10) (Lower 25)

Was there presence at Birth of  Jaundice (yellow)  Cyanosis (blue)?

### Health Questions

Current Weight \_\_\_\_\_ Current Length \_\_\_\_\_

Congenital Anomalies? Defects: \_\_\_\_\_

Infant Feeding:  BREAST  BOTTLE  FORMULA

No. of hours sleep at Night \_\_\_\_\_ Quality of Sleep:  Good  Fair  Poor

#### *Developmental History: At what age did the Child*

\_\_\_\_ Respond to sound

\_\_\_\_ Sit Alone

\_\_\_\_ Walk Alone

\_\_\_\_ Follow an Object with eyes

\_\_\_\_ Crawl

\_\_\_\_ Stand

\_\_\_\_ Hold head up

#### *Childhood Diseases:*

Chickenpox

Rubella

Other: \_\_\_\_\_

Mumps

Rubella

Measles

Whooping Cough

***Has this Child Ever Suffer From:***

**GENERAL**

- ALLERGIES
- DIZZINESS
- EAR PROBLEMS (CHRONIC ACHES)
- FATIGUE
- FREQUENT COLDS
- HEADACHES
- NOSE BLEED
- SINUS INFECTION
- SORE THROAT
- SUDDEN WEIGHT LOSS OR GAIN
- TONSILLITIS
- FAINTING
- RHEUMATIC FEVER
- CONVULSIONS
- POOR APPETITE
- SINUS PROBLEMS

**GENITO-URINARY**

- FREQUENT URINATION
- BEDWETTING

**CARDIO-VASCULAR**

- HIGH BLOOD PRESSURE
- HEART TROUBLE

**GASTROINTESTINAL**

- CONSTIPATION
- DIARRHEA
- DIGESTIVE DISORDERS
- NAUSEA & VOMITING
- STOMACH PROBLEMS

**RESPIRATORY**

- CHEST PAIN
- CHRONIC COUGH
- DIFFICULT BREATHING

**MUSCLE & JOINT**

- ARM PROBLEMS
- BROKEN BONES
- LEG PROBLEMS
- NECK PROBLEMS
- JOINT PROBLEMS

- BACKACHES
- WALKING PROBLEMS
- MUSCLE JERKING
- ORTHOPEDIC PROBLEMS
- "GROWING PAINS"
- NERITIS
- TUBERCULOSIS
- HYPERACTIVITY
- HYPERTENSION
- BEHAVIORAL PROBLEMS

- ANEMIA
- ARTHRITIS
- CANCER
- DIABETES
- HEART DISEASE
- ASTHMA
- PARALYSIS
- RUPTURES/HERNIAS
- \_\_\_\_\_

Immunization History: \_\_\_\_\_

Surgery: \_\_\_\_\_

Medications: \_\_\_\_\_

Accidents: \_\_\_\_\_

Family History: \_\_\_\_\_

***Other Treating Physicians:***

OBSTETRICIAN /MIDWIFE \_\_\_\_\_

NAME

LOCATION

PEDIATRICIAN / FAMILY M.D. \_\_\_\_\_

NAME

LOCATION

**AUTHORIZATION FOR CARE OF A MINOR**

I HEREBY AUTHORIZE THIS CLINIC AND IT'S DOCTOR(S) TO ADMINISTER CARE AS THEY DEEM NECESSARY TO MY SON/ DAUGHTER/ WARD (UPON APPROVAL OF PARENT OR GUARDIAN)

SIGNED \_\_\_\_\_ WITNESSED \_\_\_\_\_ DATE \_\_\_\_ / \_\_\_\_ / \_\_\_\_

I REALIZE THAT I AM RESPONSIBLE FOR ALL FEES CHARGED BY THIS CLINIC AND THAT I WILL PAY FOR ALL SERVICES AS THEY ARE PERFORMED. X-RAYS REMAIN THE PROPERTY OF THIS CLINIC.

DATE \_\_\_\_ / \_\_\_\_ / \_\_\_\_ SIGNATURE \_\_\_\_\_