Krueger Family Chiropractic

We would like to take this opportunity to welcome you to our office. Hopefully you are here because you heard of our great reputation. Our office is known for being a friendly casual place where people come to get healthy.

As far as we are concerned, we will do everything possible to give your child the best care we could possibly give. **We treat our patients as if they are our very own family.**

Thank you for choosing Krueger Family Chiropractic. We look forward to helping your child!

Drs. Jeff & Stephanie Krueger & the staff of Krueger Family Chiropractic

Child's (Under 2) Chiropractic Case History/Patient Information

Date:_____

Last Name:_____ First Name:_____ Middle Initial:_____

Address:_____ City:_____ State:_____ Zip:_____

Age:_____ Birth Date:_____ Most current Height_____ Weight_____

Name of Mother: _____ Name of Father:_____

Home Phone: _____ Home Phone:_____

Cell Phone: _____ Cell Phone:_____

Occupation: _____ Occupation:_____

Employer: _____ Employer:_____

Names/Ages of Siblings: _____

E-mail address: _____ (monthly newsletter may be sent)

How were you referred to our office? _____

Name of Pediatrician: _____ Date of Last Visit:_____

Reason for last visit to Peds: _____

When doctors work together it benefits you. May we have your permission to update the pediatrician regarding your child's care at this office? (check one) Yes ____ No____

Reason for Seeking Chiropractic Care

Purpose for contacting us? _____

Other Doctors Seen for this Condition: Yes____ No_____

Doctors' Names and Prior Treatments/surgeries:_____

_____

Other Health Problems or concerns? _____

Check any of the following conditions your child has suffered from during the past six months:

___Ear Infections	___Asthma/Allergies	___Digestive Problems
___Colic	___Seizures	___Difficulty Sleeping
___Car Accident	___Recurring Fever	___Temper Tantrums
___"Clicky" Hips	___Flattening of the head	___Other:_____

Prescriptions child is taking:_____

Any Position your child does not like (turning head to right, lying on back, etc)?_____

_____

Is there any Family History of Childhood/Genetic disease? _____

Pre Natal History

Name of Obstetrician or Midwife: _____

Any Complications during birth? _____

Check all that apply ___Vaginal ___C-section ___Emergency ___Forceps used ___Vacuum Extraction

Any Meds during Pregnancy/Delivery? ___Yes ___No Birth Weight & Length_____

CongenitalDefects/Anomalies_____

_____

Feeding History

Breast Fed: ___Yes ____No How Long? _____ Formula Fed: ___Yes ___No How Long?_____

Intro to Solids: _____Months

Food/Juice Allergies Intolerances: ___Yes ___No List_____

Developmental History

During your child's development their spine is the most vulnerable to stress and regular check-ups by a Doctor of Chiropractic are for the prevention and early detection of stresses on their growing spine and nervous system. Did you notice and differences, difficulties or may have skipped some of the following stages(if applicable):

___Response to Sound ___Hold Head Up ___Sit Up ___Rolling Over ___Self Feeding

___Walking Alone ___Cross Crawl ___Stand Alone ___Walking Alone

Has your child ever been involved in a car accident? ___Yes ___No List:_____

Prior Surgery? ___Yes ___No List:_____

Childhood Diseases:

Chicken Pox	___Yes ___No Age____	Measles	___Yes ___No Age____
Mumps	___Yes ___No Age____	Whooping Cough	___Yes ___No Age____
Rubella	___Yes ___No Age____	Other_____	

Please circle any and all insurance coverage that may be applicable in this case**:**
Health Insurance Worker's Compensation Medicaid Medicare Auto Accident
Medical Savings Account & Flex Plans Other
Name of Primary Insurance Company:_____
Name of Secondary Insurance Company (if any):_____
Who is responsible for this account?_____

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to Dr. Krueger or Krueger Family Chiropractic. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.

Patient's Name:_____

Guardian's Name Authorizing Care:_____

Guardian's Signature Authorizing Care:_____ Date:_____