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 (Over 2) Chiropractic Case History/Patient Information

Date:__________________

Last Name:__________________________ First Name:_______________________ Middle Initial:_______

Address:____________________________________City:___________________ State:______ Zip:___________

Age:___________ Birth Date:_____________________ 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 will be sent)

How were you referred to our office?____

Name of Pediatrician:____ Date of Last Visit:______________

Reason for Visit:____

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?____

When and how did this start?____

Other Doctors Seen for this Condition: Yes____ No_____. Doctors' Names and Prior Treatments:____________

____

Other Health Problems? ____

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

___Ear Infections	___Asthma/Allergies	___Digestive Problems	___ADHD
___Bed Wetting	___Seizures	___Difficulty Sleeping	___Chronic Colds
___Car Accident	___Recurring Fever	___Temper Tantrums	___Scoliosis
___Back Pain	___Headaches	___GrowingPains	

___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?____

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

___Talking

Is/has your child been involved in any high impact or contact type sports (i.e. Soccer, Football, Gymnastics, Cheerleading, Martial Arts, Etc)? ___Yes ___No List:____

____

Any Previous Chiropractic Care?____

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

Prior Surgery? ___Yes ___No List:____

Been Hospitalized? ___Yes ___No List:____

Childhood Diseases:

Chicken Pox ___Yes ___No Age____ Measles ___Yes ___No Age____

Mumps ___Yes ___No Age_____ Rubella ___Yes ___No Age____

Whooping Cough ___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:______________