Your Child's Name: _____ **Birth Date:** _____

□ Check here if you would like to discuss this information by telephone without your child present.

General Information about Your Child:

Age: _____ Sex (circle): Girl Boy

Mother's Name: _____ Father's Name: _____

Address: _____ Address: _____

City: _____ City: _____

State/Zip _____ State/Zip _____

Occupation: _____ Occupation: _____

Daytime Phone: _____ Daytime Phone: _____

Evening Phone: _____ Evening Phone: _____

Cell Phone: _____ Cell Phone: _____

Name of School: _____

Address: _____ Phone: _____

Grade: _____ Teacher's Name: _____ Subject: _____

Teacher's Name: _____ Subject: _____

Teacher's Name: _____ Subject: _____

Teacher's Name: _____ Subject: _____

Who told you about Dr. Klug? _____

Your Child's Current Problem(s)

What problem(s) would you like Dr. Klug to address? _____

Does your child differ from other siblings or playmates? Please describe: _____

Who first noticed your child's problem(s) and what did they notice? _____

Did the problem occur gradually or suddenly? Please explain: _____

What makes your child's problem worse? _____

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Your Child's Name: _____ **Birth Date:** _____

What makes your child's problem better? _____

Is your child's problem always present or does it come and go? If it comes and goes, explain how long it will last and how often it occurs. _____

Who else has your child seen for evaluation of this problem? What did they do? How did they help? _____

Has your child had any studies performed to evaluate the problem? If so, list the area studied and the result:

X-rays: _____

CT Scans: _____
MRI Scans: _____
Myelogram: _____
EEG (Electroencephalogram): _____
EMG (Electromyelogram): _____
Neuropsych evaluation: _____
Other: _____

What have you done on your own that has helped your child's problem? _____

Prenatal History (Please check all that apply)

	Yes
Miscarriage or stillbirth prior to this child?	☐
Any deaths before age one?	☐
Rhogam Injections (for blood Rh factor)?	☐
Toxemia, Pre-eclampsia or Eclampsia?	☐
High Blood Pressure?	☐

Your Child's Name: _____ **Birth Date:** _____

	Yes
Gestational Diabetes?	☐
Spotting or bleeding?	☐
Trauma or illness?	☐
Adequate weight gain?	☐
Was child active in the womb until delivery?	☐
Labor before 37 weeks gestation?	☐
Did mother work during pregnancy? (explain)	☐
Fillings or other dental work during pregnancy?	☐
Cigarette Use?	☐
Alcohol Use?	☐
Street Drug Use?	☐

Medication Use (please list): _____

Comments or additional explanation: _____

Delivery History

Length of pregnancy (in weeks) _____ Birth weight _____

Apgar scores (one and five minutes) _____ Birth length _____

Labor (Please check all that apply)

"Water Broke" On Its Own	☐	Spontaneous Labor	☐	Induced Labor	☐
Vaginal Delivery	☐	Cesarean	☐	"Back Labor"	☐
Problem delivering shoulder(s)	☐	Breech	☐	"Sunny Side Up"	☐
Delayed or stalled labor	☐	Vacuum	☐	Forceps	☐
Problem on fetal monitor strip	☐	Fast Labor	☐	Pain medicine	☐
Delivered laying on back	☐	General Anesthesia	☐	Epidural	☐
Meconium (green amniotic fluid)	☐				

Comments or additional explanation: _____

Nursery History (Please check all that apply)

Resuscitation	☐	NICU	☐	Respiratory distress	☐
Intubation	☐	Oxygen	☐	Severe jaundice	☐
Infection	☐	Seizures	☐	Incubator	☐
Cried Immediately at delivery	☐	Immediate latch	☐	Coordinated suck	☐
Loud "vigorous" cry at delivery	☐	Spit-up or reflux	☐	Easily consoled	☐
Cried appropriately (when hungry, wet, or needed to be held)	☐			Slept well	☐

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Your Child's Name: _____ **Birth Date:** _____

Overlapping head bones after 1 week □ | Breast Fed □ | Breast fed how long? ____
Comments or additional explanation: _____

Developmental History (If you do not know the age, check early, average or late)

	Age	Early	Average	Late
Sit unaided		□	□	□
Belly or army crawl		□	□	□
Crawl on all fours		□	□	□
Stand unaided		□	□	□
Walk unaided		□	□	□
Run		□	□	□
Skip		□	□	□
First baby tooth		□	□	□
First permanent tooth		□	□	□
Toilet Trained		□	□	□
Button clothes		□	□	□
Zip zipper		□	□	□
Tie shoe laces		□	□	□
First word		□	□	□
Short Sentences		□	□	□

	Yes
Child slept on back or side as infant?	□
Child wets bed?	□
Child prefers active play?	□
Child walks or runs aimlessly or "drunkenly"?	□
Speech was clear?	□
Child can express thoughts clearly?	□

Comments or additional explanation: _____

Sensory Issues (Please check all that apply)

Hyper-active	□	Unaware of touch or pain	□
Touches others too often or too hard	□	Engages in unsafe behaviors such as climbing too high	□
Enjoys loud sounds	□	Does not like being touched	□
Fears heights or gets motion sickness	□	Avoids or dislikes swinging movements or being held in the air	□

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Cautious, unwilling to try new things	☐	Uncomfortable in loud or busy places	☐
Picky eater or very sensitive to smells	☐	Very poor fine motor skills such as handwriting	☐
Very poor gross motor skills such as catching, kicking or throwing balls	☐	Difficulty imitating movements, such as "Simon Says" or "Hokey Pokey"	☐
Trouble with balance, sequences of movements or coordinating both sides of body.	☐		

Hand Use History (Please circle choice or check box)

Child's hand preference	none	R	L	Always prefers that hand?	☐
Hand for eating?		R	L	Hand for throwing a ball?	R L
Child knows right from left?		☐		Child is skillful with hands?	☐

Comments or additional explanation: _____

Academic Performance (Please check all that apply)

	With severe difficulty	With moderate difficulty	Success with Tutor	No difficulty	Grade Level
Reading	☐	☐	☐	☐	_____
Spelling	☐	☐	☐	☐	_____
Writing	☐	☐	☐	☐	_____
Math	☐	☐	☐	☐	_____
Physical Education	☐	☐	☐	☐	_____
Science	☐	☐	☐	☐	_____
History	☐	☐	☐	☐	_____
Foreign Language	☐	☐	☐	☐	_____
Other	☐	☐	☐	☐	_____

Comments or additional explanation: _____

Age started pre-school _____ Years _____ Months
Age started kindergarten _____ Years _____ Months
Age started first grade _____ Years _____ Months

Has child repeated a grade? ☐ Which grade was repeated? _____
Child likes school? ☐
Child likes teacher? ☐

Your Child's Name: _____ **Birth Date:** _____

Child likes fellow students? □
Child has a best friend? □
Child's favorite subject is: _____
Child's least favorite subject is? _____
Comments or additional explanation: _____

Medical History (Please check all that apply)

Knocks on head, "goose-egg"	□	Knocked unconscious or "saw stars"	□
Wind knocked out	□	Broken bones	□
Sprains/strains	□	Motor vehicle accidents	□
Organized athletics or sports	□	Tooth extractions, fillings or other dental work	□
Orthodontia	□	High Fever	□
Eczema	□	Asthma	□
Hospitalizations	□	Frequent respiratory infections	□
Severe Ear Infection	□	Vaccine reaction (s)	□
Food Allergies	□	Environmental Allergies	□
Surgery	□	Antibiotic use before age 1 year	□

Comments or additional explanation: _____

Family History to three generations (siblings, parents and grandparents)

	Yes	Relationship
Multiple births	□	
Hereditary diseases	□	
Psychiatric disorders (depression, bipolar, etc.)	□	
Left-handedness	□	
Speech delays or difficulties	□	
Reading or writing difficulties	□	
	Yes	**Relationship**
Hyperactivity	□	
ADD or ADHD	□	
Autism, Asperger's or PDD	□	
Bilingual Parent or Caregiver	□	
Visual problems	□	
Hearing problems	□	
Allergies (please specify)	□	

Your Child's Name: _____ **Birth Date:** _____

Comments or additional explanation: _____

Family Environment History

Parents		Parent is child's…	Mother	Father
Married	☐	Birth Parent	☐	☐
Divorced (years ago)	_____	Step Parent	☐	☐
Father Deceased (years ago)	_____	Adoptive Parent	☐	☐
Mother Deceased (years ago)	_____	Foster Parent	☐	☐

Birth order (i.e. 3rd of 6) _____

Siblings Names	Age	Step	Adopted	Birth
		☐	☐	☐
		☐	☐	☐
		☐	☐	☐
		☐	☐	☐

Comments or additional explanation: _____

_____ _____
Signature of Parent or Guardian Date

_____ _____
B.S. Klug, D.O. Date

Please complete the general patient questionnaire found at www.HealthSpanKC.com for your child as well. Thank you.

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