

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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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 (Electromyogram): _____

Neuropsych evaluation: _____

Other: _____

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

Prenatal History (Please check all that apply)

- | | <u>Yes</u> |
|--|--------------------------|
| Miscarriage or stillbirth prior to this child? | <input type="checkbox"/> |
| Any deaths before age one? | <input type="checkbox"/> |
| Rhogam Injections (for blood Rh factor)? | <input type="checkbox"/> |
| Toxemia, Pre-eclampsia or Eclampsia? | <input type="checkbox"/> |
| High Blood Pressure? | <input type="checkbox"/> |
| Gestational Diabetes? | <input type="checkbox"/> |
| Spotting or bleeding? | <input type="checkbox"/> |
| Trauma or illness? | <input type="checkbox"/> |
| Adequate weight gain? | <input type="checkbox"/> |
| Was child active in the womb until delivery? | <input type="checkbox"/> |
| Labor before 37 weeks gestation? | <input type="checkbox"/> |



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Yes

- 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)

- | | | | |
|--|---|--|--------------------------|
| <input type="checkbox"/> "Water Broke" On Its Own | <input type="checkbox"/> Spontaneous Labor | <input type="checkbox"/> Induced Labor | <input type="checkbox"/> |
| <input type="checkbox"/> Vaginal Delivery | <input type="checkbox"/> Cesarean | <input type="checkbox"/> "Back Labor" | <input type="checkbox"/> |
| <input type="checkbox"/> Problem delivering shoulder(s) | <input type="checkbox"/> Breech | <input type="checkbox"/> "Sunny Side Up" | <input type="checkbox"/> |
| <input type="checkbox"/> Delayed or stalled labor | <input type="checkbox"/> Vacuum | <input type="checkbox"/> Forceps | <input type="checkbox"/> |
| <input type="checkbox"/> Problem on fetal monitor strip | <input type="checkbox"/> Fast Labor | <input type="checkbox"/> Pain medicine | <input type="checkbox"/> |
| <input type="checkbox"/> Delivered laying on back | <input type="checkbox"/> General Anesthesia | <input type="checkbox"/> Epidural | <input type="checkbox"/> |
| <input type="checkbox"/> Meconium (green amniotic fluid) | | | |
- Comments or additional explanation: _____

Nursery History (Please check all that apply)

- | | | | |
|---|--|---|--------------------------|
| <input type="checkbox"/> Resuscitation | <input type="checkbox"/> NICU | <input type="checkbox"/> Respiratory distress | <input type="checkbox"/> |
| <input type="checkbox"/> Intubation | <input type="checkbox"/> Oxygen | <input type="checkbox"/> Severe jaundice | <input type="checkbox"/> |
| <input type="checkbox"/> Infection | <input type="checkbox"/> Seizures | <input type="checkbox"/> Incubator | <input type="checkbox"/> |
| <input type="checkbox"/> Cried Immediately at delivery | <input type="checkbox"/> Immediate latch | <input type="checkbox"/> Coordinated suck | <input type="checkbox"/> |
| <input type="checkbox"/> Loud "vigorous" cry at delivery | <input type="checkbox"/> Spit-up or reflux | <input type="checkbox"/> Easily consoled | <input type="checkbox"/> |
| <input type="checkbox"/> Cried appropriately (when hungry, wet, or needed to be held) | <input type="checkbox"/> | <input type="checkbox"/> Slept well | <input type="checkbox"/> |
| <input type="checkbox"/> Overlapping head bones after 1 week | <input type="checkbox"/> Breast Fed | <input type="checkbox"/> Breast fed how long? | _____ |
- Comments or additional explanation: _____



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

	<u>Age</u>	<u>Early</u>	<u>Average</u>	<u>Late</u>
Sit unaided	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Belly or army crawl	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crawl on all fours	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stand unaided	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walk unaided	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Run	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skip	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
First baby tooth	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
First permanent tooth	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Toilet Trained	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Button clothes	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Zip zipper	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tie shoe laces	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
First word	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Short Sentences	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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 | <input type="checkbox"/> | Unaware of touch or pain | <input type="checkbox"/> |
| Touches others too often or too hard | <input type="checkbox"/> | Engages in unsafe behaviors such as climbing too high | <input type="checkbox"/> |
| Enjoys loud sounds | <input type="checkbox"/> | Does not like being touched | <input type="checkbox"/> |
| Fears heights or gets motion sickness | <input type="checkbox"/> | Avoids or dislikes swinging movements or being held in the air | <input type="checkbox"/> |
| Cautious, unwilling to try new things | <input type="checkbox"/> | Uncomfortable in loud or busy places | <input type="checkbox"/> |
| Picky eater or very sensitive to smells | <input type="checkbox"/> | Very poor fine motor skills such as handwriting | <input type="checkbox"/> |
| Very poor gross motor skills such as catching, kicking or throwing balls | <input type="checkbox"/> | Difficulty imitating movements, such as "Simon Says" or "Hokey Pokey" | <input type="checkbox"/> |
| Trouble with balance, sequences of movements or coordinating both sides of body. | <input type="checkbox"/> | | <input type="checkbox"/> |



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Hand Use History (Please circle choice or check box)

Child's hand preference	none	R	L	Always prefers that hand?	<input type="checkbox"/>
Hand for eating?		R	L	Hand for throwing a ball?	R <input type="checkbox"/> L <input type="checkbox"/>
Child knows right from left?		<input type="checkbox"/>		Child is skillful with hands?	<input type="checkbox"/>

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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Spelling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Writing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Math	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Physical Education	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Science	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
History	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Foreign Language	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

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?

Child likes fellow students?

Child has a best friend?

Child's favorite subject is: _____

Child's least favorite subject is? _____

Comments or additional explanation: _____



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Medical History (Please check all that apply)

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

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

- | | <u>Yes</u> | <u>Relationship</u> |
|---|--------------------------|---------------------|
| Multiple births | <input type="checkbox"/> | _____ |
| Hereditary diseases | <input type="checkbox"/> | _____ |
| Psychiatric disorders (depression, bipolar, etc.) | <input type="checkbox"/> | _____ |
| Left-handedness | <input type="checkbox"/> | _____ |
| Speech delays or difficulties | <input type="checkbox"/> | _____ |
| Reading or writing difficulties | <input type="checkbox"/> | _____ |
| | <u>Yes</u> | <u>Relationship</u> |
| Hyperactivity | <input type="checkbox"/> | _____ |
| ADD or ADHD | <input type="checkbox"/> | _____ |
| Autism, Asperger's or PDD | <input type="checkbox"/> | _____ |
| Bilingual Parent or Caregiver | <input type="checkbox"/> | _____ |
| Visual problems | <input type="checkbox"/> | _____ |
| Hearing problems | <input type="checkbox"/> | _____ |
| Allergies (please specify) | <input type="checkbox"/> | _____ |
| Comments or additional explanation: _____ | | |



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Family Environment History

<u>Parents</u>		<u>Parent is child's...</u>	<u>Mother</u>	<u>Father</u>
Married	<input type="checkbox"/>	Birth Parent	<input type="checkbox"/>	<input type="checkbox"/>
Divorced (years ago)	_____	Step Parent	<input type="checkbox"/>	<input type="checkbox"/>
Father Deceased (years ago)	_____	Adoptive Parent	<input type="checkbox"/>	<input type="checkbox"/>
Mother Deceased (years ago)	_____	Foster Parent	<input type="checkbox"/>	<input type="checkbox"/>

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

<u>Siblings Names</u>	<u>Age</u>	<u>Step</u>	<u>Adopted</u>	<u>Birth</u>
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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.bethanyklug.com for your child as well. Thank you.



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