TMJ & Sleep Therapy Centre

CORRECTIVE CARE INFANT HEALTH QUESTIONNAIRE

Today's Date: _____

Child Demographic Information

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

Gender: ☐ Male ☐ Female Date of Birth: _____ Age: _____ Height: _____ ft _____ in Weight: _____ lbs

Address: _____ Address 2: _____

City: _____ State: _____ Zip Code: _____

Parent/Guardian Contact Information

Parent/Guardian Full Name: _____ Relationship to Patient: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email: _____

Referral Information - how did you hear about us?

Referral Name/Source: _____

Referral Type: ☐ Doctor ☐ Dentist ☐ Specialist ☐ Patient ☐ Other _____

Reason for Appointment

What is your concern regarding your infant? _____

_____

Pregnancy

Have you had any previous pregnancies? ☐ Yes ☐ No If yes, how many? _____

Pregnancy: ☐ Normal ☐ Difficult If difficult, please explain: _____

_____

Delivery: ☐ Term ☐ Pre-Term ☐ Post-Term

Was this an easy delivery? ☐ Yes ☐ No

Check all that apply to the delivery of this child: ☐ Forceps ☐ Vacuum Extraction ☐ Induced with Pitocin

Child's Birth Length: _____ ft _____ in Child's Birth Weight: _____

Feeding: ☐ Breastfed ☐ Bottle Until Age: _____

Is he/she an only child? ☐ Yes ☐ No If no, what number child is this one? _____

APGAR Scores (if known): _____

Has your child had any of the following issues?

____Colicky ____Poor Sleep ____Restless

____Irritable ____Feeding Difficulties ____Recurrent Infections

____Allergies ____Other _____

Is your child taking any medications or supplements? ☐ Yes ☐ No If yes, which medications? _____

_____

_____

TMJ & Sleep Therapy Centre
7221 N. Fir Road
Granger, IN 46530

Has your child had any surgeries or illnesses? ☐ Yes ☐ No If yes, please explain: _____

Anything else you would like to add? _____

Prior Surgeries

	Procedure	Date
1.		
2.		
3.		

Family Health History

Does your family have a history of any of the following?

Cancer	☐ Yes	☐ No	Who?
Obesity (overweight)	☐ Yes	☐ No	Who?
High Blood Pressure	☐ Yes	☐ No	Who?
Heart Trouble	☐ Yes	☐ No	Who?
Stroke	☐ Yes	☐ No	Who?
Asthma	☐ Yes	☐ No	Who?
Allergies	☐ Yes	☐ No	Who?
Diabetes (sugar)	☐ Yes	☐ No	Who?
Ulcers	☐ Yes	☐ No	Who?
Stomach or Bowel Problems	☐ Yes	☐ No	Who?
Gout	☐ Yes	☐ No	Who?
Kidney Disease	☐ Yes	☐ No	Who?
Arthritis	☐ Yes	☐ No	Who?
Hay Fever	☐ Yes	☐ No	Who?
Nerve/Muscle Diseases	☐ Yes	☐ No	Who?
Seizures (fits, epilepsy)	☐ Yes	☐ No	Who?
Anemia (low blood)	☐ Yes	☐ No	Who?
Bleeding Problems	☐ Yes	☐ No	Who?
Rheumatic Fever	☐ Yes	☐ No	Who?
Alcoholism	☐ Yes	☐ No	Who?
Mental Illness	☐ Yes	☐ No	Who?
Physical Deformity	☐ Yes	☐ No	Who?
Blind/Deaf	☐ Yes	☐ No	Who?
Mental Retardations	☐ Yes	☐ No	Who?
Hereditary Problem	☐ Yes	☐ No	Who?
Death by Accident	☐ Yes	☐ No	Who?

Other problems not mentioned: _____

Signature

☐ I acknowledge that I have been offered a copy of the Office Privacy Notice and I am familiar with my rights as a patient of Dr. Klauer and TMJ & Sleep Therapy Centre. I understand this practice is Fee for Service Out-of-Network and regardless of my insurance coverage, I am responsible for any charges incurred at the time of my visit.

Parent/Guardian Signature: _____ Date: _____

My signature above certifies that the information listed on this form is accurate and complete to the best of my knowledge.