## REGISTRATION INFORMATION

DATE _____

**PATIENT** _____
LAST NAME FIRST NAME

DOB _____ MALE _____ FEMALE _____

SOCIAL SECURITY # _____

**RESPONSIBLE PARTY** _____
LAST NAME FIRST NAME

RELATIONSHIP TO PATIENT _____

HOME PHONE _____ CELL PHONE _____

STREET ADDRESS _____

CITY _____ STATE _____ ZIP _____

EMPLOYED BY _____

OCCUPATION _____ BUSINESS PHONE _____

SOCIAL SECURITY # _____

**MEDICAL INSURANCE** YES ____ NO ____

INSURANCE COMPANY _____

POLICY # _____ GROUP # _____

EMERGENCY CONTACT _____ PHONE # _____

PHARMACY NAME _____ PHONE # _____

REFERRED BY WHOM _____

COMMENTS _____

SIGNATURE OF PARENT _____

# PATIENT HISTORY FORM

CHILD'S NAME _____ AGE _____ TODAY'S DATE _____

## A. BIRTH HISTORY

1. Date of Birth _____
2. Birthplace _____
3. Any pregnancy complications? _____
4. Any delivery complications? _____
5. Full Term or Pre-Term? _____
6. Birth weight _____
7. Any nursery problems? _____

## B. GROWTH AND DEVELOPMENT

1. Weight problems _____
2. Height problems _____
3. Any developmental problems?
   - Language _____
   - Social _____
   - Fine Motor _____
   - Gross Motor _____
4. Any school problems?
   - Learning Disabilities _____
   - Discipline/Behavioral problems

   _____

## C. PAST MEDICAL HISTORY

1. Any chronic illnesses (asthma, diabetes, migraines)

   _____

   _____
2. Any history of contagious diseases? _____

   _____
3. Any diet restrictions? _____

   _____
4. Are immunizations up to date? _____

   * Please provide our office with the documentation *

## D. MEDICATIONS

_____

_____

## E. HOSPITALIZATIONS

(When, Where, Why) _____

_____

_____

## F. SURGERIES

(When, Where, Why) _____

_____

_____

## G. SERIOUS INJURIES _____

_____

_____

## H. ALLERGIES

Medications _____

Food _____

Environmental _____

## I. FAMILY HISTORY

1. Father: Living? _____ Age _____
   Medical problems _____
2. Mother: Living? _____ Age _____
   Medical problems _____
3. Siblings: How many? _____ Ages _____
   Medical problems _____
4. Any family history of: (check all that apply)
   Diabetes ____ Asthma ____ Allergies ____
   Heart disease ____ TB ____ Cancer ____
   Seizures ____ Mental Illness ____
   Bowel problems ____

## J. GENERAL SURVEY

Does your child have problems with any of the following:

Head _____

Eyes _____

Ears/Nose/Throat _____

Chest/Heart/Lungs _____

Stomach/Bowel _____

Kidneys/Bladder _____

Bones/Muscles/Joints _____

Skin _____

Blood _____

## K. YOUR LAST DOCTOR WAS

_____