



Patient Registration Form

Patient Name (Last, First):	DOB:	Male Female Other
Parent # 1 Name (Last, First):	DOB:	Occupation:
Address:	City/State	Zip code:
Employer:		Parent Mobile #:
Email:		Home #:
Parent # 2 Name (Last, First):	DOB:	Occupation:
Address:	City/State	Zip code:
Employer:		Parent Mobile #:
Email:		Home #:
Child's parents are: <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Other: _____		
Emergency Contact/Relationship:		Phone #:
Primary Language(s) Spoken at Home: English Other:		
Ethnicity: <input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> American Indian <input type="checkbox"/> African American <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Other		
Siblings Name (Last, First)	Birth Date	Male Female Other

Social History/ Safety Issues

Who lives in the home? _____

Do any household members smoke? Yes No

Do you have a gun in your home? Yes No Are they locked up? Yes No

Are there any pets in your home? Yes No (Specify:) _____

Does your child attend daycare/preschool/school? Yes No Grade: _____ School Name: _____

Any concerns about school performance? Yes No Specify: _____



Birth History

Delivery Hospital: _____ Your Ob: _____

Were there any problems with the pregnancy? No Yes (Please Specify) _____

Was the baby full term _____ or premature? _____ If so, how early _____

NICU: Yes No If yes, reason for NICU hospitalization: _____

Delivered by: Vaginal Birth Caesarian (Please explain why:) _____

Birth Weight: _____ Birth Length: _____ Passed Hearing Screen? Yes No

Patient Medical History

Allergies: Yes No If yes; specify _____

Does your child Take: Vitamins Supplements Special Diet Medications

If yes, please explain:

Has your child had any surgeries? No Yes; If yes, please list year and type of surgery below:

Has your child had any **hospitalizations/illnesses/injuries**? No Yes; If yes, please list year and explain below:

Has your child seen any specialists/therapists? No Yes; If yes, please list doctor(s), and reason for specialty care:



Please check below if your CHILD has/has any of the following?

<input type="checkbox"/> ADD/ADHD	<input type="checkbox"/> Developmental Delay	<input type="checkbox"/> Migraines	<input type="checkbox"/> UTI/Kidney Infection
<input type="checkbox"/> Allergy(eyes, nose, skin)	<input type="checkbox"/> Food allergies	<input type="checkbox"/> Obesity	<input type="checkbox"/> Other:
<input type="checkbox"/> Anemia	<input type="checkbox"/> Frequent ear infections	<input type="checkbox"/> Frequent Infections	
<input type="checkbox"/> Asthma	<input type="checkbox"/> Hearing Problems	<input type="checkbox"/> Seizures/epilepsy	
<input type="checkbox"/> Autoimmune condition	<input type="checkbox"/> Heart Condition	<input type="checkbox"/> Skin problems	
<input type="checkbox"/> Bleeding Problems	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Snoring	
<input type="checkbox"/> Constipation/diarrhea	<input type="checkbox"/> Immune Problems	<input type="checkbox"/> Speech Difficulty	
<input type="checkbox"/> Eczema	<input type="checkbox"/> Gastroesophageal reflux	<input type="checkbox"/> + TB test	
<input type="checkbox"/> Depression/Anxiety	<input type="checkbox"/> Learning Disability	<input type="checkbox"/> Thyroid Problems	

Family History (Please specify which family member)

<input type="checkbox"/> Alcoholism/Drug abuse:	<input type="checkbox"/> Thyroid disease (specify):
<input type="checkbox"/> ADHD/Learning Disabilities:	<input type="checkbox"/> High Cholesterol:
<input type="checkbox"/> Asthma:	<input type="checkbox"/> High Blood Pressure:
<input type="checkbox"/> Allergies/ Hay fever:	<input type="checkbox"/> Congenital hearing loss:
<input type="checkbox"/> Food allergy:	
<input type="checkbox"/> Bleeding/Clotting problems:	<input type="checkbox"/> Heart attack (before 50):
<input type="checkbox"/> Depression/Mental illness/ anxiety:	<input type="checkbox"/> Heart disease/Sudden unexplain death before age 50:
<input type="checkbox"/> Diabetes (specify):	<input type="checkbox"/> Inherited genetic disease/birth defects; (specify)
<input type="checkbox"/> Eczema:	
<input type="checkbox"/> Kidney Disease:	<input type="checkbox"/> Other:
<input type="checkbox"/> Seizures/Febrile seizures:	