Patient Registration Packet

Child's Name:________________________

Household Information

Please list all those living in the child's home.

Name	Relationship to child	Birth Date	Health Problems

What is the child's living situation?

☐ Lives with mother and father ☐Lives with adoptive parents ☐Joint custody ☐Single custody ☐Foster family

If one or both parents are not living in the home, how often does the child see the parent(s) not in the home? _______

____

____

BIRTH HISTORY

☐ **Birth History unknown**

☐Vaginal ☐C-Section ☐Full Term ☐Premature (if yes, weeks completed _______) Birth Weight: ___________ Length: ____________

Were there any prenatal or neonatal complications? ☐Yes ☐No

Was a NICU stay required? ☐Yes ☐No (if yes please explain): ____

____

GENERAL HISTORY

Do you consider your child to be in good health? ☐ Yes ☐No
If no, please explain: ____

____

Do you think your child's development is: ☐ On Target ☐Delayed
If delayed, please explain: ____

____

Has your child ever been hospitalized or had surgery: ☐ Yes ☐No
If yes, please explain: ____

____

Is your child allergic to medications or foods ☐Yes ☐No
If yes, please explain: ____

____

Form Completed By (Print):____

Signature:____ **Date:**_________________

Patient Registration Packet

Patient Medical History

Child's Name:________________________

GENERAL HISTORY QUESTIONS	Yes	No	Unknown	When/explain
Has your child ever had an allergy to any medication, food or environmental? If so, which one(s)				
Has your child ever wheezed or used an inhaler?				
Has your child ever been hospitalized in the last year? If so, for what?				
Has your child ever had a head injury requiring medical attention?				
Has your child ever had surgery				
Does your child have any ongoing medical problems?				
Does your child have a special diet or vegetarian diet? If so, please describe diet				
Has your child ever lived/spend time in an older building that has not been renovated since 1978?				
Is there a gun kept in the place where your child lives?				
If yes to the gun question, is the gun locked up/ammo separate?				
HAS YOUR CHILD EVER HAD OR NOW HAVE	**Yes**	**No**	**Unknown**	**When/explain**
Eye/Vision problem				
Ear/Hearing problem				
Dental problems				
Speech problems				
Fainting spells				
Urine/Kidney Infections				
Wheezing or Asthma				
Heart Condition/Heart murmur				
Anemia/Blood problems				
Bedwetting				
Seizures/Convulsions				
Recurrent skin rash/Eczema				
Joint pain or swelling				
Fractures/Bone problems				
Lung, liver or blood infections				
Tuberculosis or positive TB test				
Other:				
DOES CHILD	**Yes**	**No**	**Unknown**	**When/explain**
Have immunizations up-to-date				
Take medicine regularly				
See dentist regularly				
HAS YOUR CHILD EVER HAD OR NOW HAVE	**Yes**	**No**	**Unknown**	**When/explain**
Frequent headaches				
Discipline problems				
Trouble getting along with others				
Restlessness/Fidgety				
Nervousness or Fearful				
Persistently sad or depressed				
Drug/Tobacco/Alcohol use				
Sexual activity or Molestation				
Trouble in school				
Aggressive behavior				
Eating problems/Eating too much/little				

Employee Initials: _________