

Registration

Today's Date _____

Name _____ Birth Date _____ Sex: M F

Child's Parent's Names _____

Address:

Home Phone _____ Cell# _____

Work # _____ E-mail _____

Do you wish to receive informational newsletters via E-mail? Yes No

Occupation _____

SSN # _____

Health Insurance Carrier _____

Primary Physician _____

Other Health Providers Seen Regularly (including alternative/complementary providers)

Name _____ Specialty _____

Referred By _____

Note: All information is confidential and will be released only with your signed consent

Health History - Child

Name _____ Birth date _____

Please list your main concerns:

What diagnoses or explanations have been given to you about your child? _____

Was there any event or illness that you or others feel brought on your child's symptoms? _____

Family History

Check if family history is unknown

	Age	Health Problems		Age	Health Problems
Mother	_____	_____	Father	_____	_____
Sibling	_____	_____	Sibling	_____	_____
Sibling	_____	_____	Sibling	_____	_____
Maternal GM	_____	_____	Maternal GF	_____	_____
Paternal GM	_____	_____	Paternal GF	_____	_____

YES	RELATIONSHIP	YES	RELATIONSHIP	YES	RELATIONSHIP
	Alcohol/Drug Problem		Endocrine/Hormonal Imbalance		Gastro intestinal Disease
	Allergy/Asthma		High Blood Pressure		Skin Disease
	Anemia		High Cholesterol/Fat		ADD/ADHD
	Arteriosclerosis		Kidney Disease		Anxiety
	Arthritis		Liver Disease		Depression
	Binge Eating/Bulimia		Mental Illness		Other...
	Bleeding Problem		Obesity		
	Cancer		Stroke		
	Diabetes		Suicide		
	Epilepsy/Seizure		Thyroid Disease		
	Heart Disease		Tuberculosis		

Health History

Name _____ Birth date _____

Pregnancy: Any illnesses/complications? _____

Medications: _____

Any stressful life events during pregnancy? _____

Labor and Delivery: Any complications? _____

Mode Of Delivery: Vaginal spontaneous ___ Vaginal w/ forceps ___ Vaginal w/ suction ___
C-Section _____ Reason _____

Medications during Labor and Delivery: _____

Full Term _____ Premature _____ Weeks _____

Apgar Scores _____ 1 min. _____ 5 min. _____

Complications in newborn period: _____

Medications given to baby during hospital stay? _____

Past History Of Illness And Medical Problems

Surgery: List all surgery and approximate dates _____

Other hospitalizations and dates _____

Broken bones and other traumatic injuries (include all car accidents or concussions) _____

Emergency room visits (dates) _____

YES		WHEN	YES		WHEN	YES		WHEN	YES		WHEN
	abdominal pain -chronic			cancer			endometriosis			menstrual prob- lem	
	acne			cataract			hay fever/allerg- gies			mental disease	
	AIDS			chemical sensitivity			hearing problem			migraine	
	allergies			chicken pox			heparitis			mononucleosis	
	amalgams/silver gfillings			chronic diarrhea			herpes			nervous condi- tion	
	anemia			chronic fatigue			hiatal hernia			neurologic problem	
	antibiotics more than once a year			colds, frequen			high blood pres- sure			overweight (20 lbs.)	
	anorexia			colic			high cholester- ol/triglycerides			panic attacks	
	anxiety			colitis			hives			pelvic infection	
	arthritis			congenital defect			hypoglycemia			peptic ulcer	
	asthma			constipation			hyperactivity			pneumonia	
	attantion problem			counseling			insomnia			premenstrual tension	
	back pain/strain			croup			jaundice			psychotherapy	
	bed wetting			depression			kidney infection			reactions to vac- cinations	
	blood clots			diabetes			kidney stones			reflux	
	breast lump			dyslexia			kidney problem			rheumatic fever	
	bronchitis			ear infection			learning dis- ability			root canal	
	bulimia (self in- duced vomiting)			eczema			liver disease			scoliosis	
	scarlet fever			seizures			sexually trans- mitted disease			sinusitis	
	skin problem			sleep disorder			suicide attempt			syphilis	
	taken steroid (cortisone/predni- sone)			thrush			thyroid problem			tics	
	tonsillitis			tooth problems			urine problem			vaginitis	
	vision problem			warts			whooping cough				

Signs And Symptoms

Please check any sign and symptoms which your child demonstrates.

YES		YES		YES		YES		YES		YES	
	excessive fatigue		chills		flushing (external ears)		leg cramps		anal itching		low self-esteem
	cold intolerance		headaches		sensitive to sounds		joint pain		frequent urination		always fidgeting in seat
	heat intolerance		poor memory		ringing/buzzing in ears		joint swelling		pain with urination		difficulty falling asleep
	cold hands and feet		difficulty concentrating		nosebleeds		shortness of breath w/ exertion		foul odor to urine		obsessive compulsive behaviors
	flushing		clumsiness		nose itching		belching		rocking		bed-wetting
	dizziness		numbness/tingling		excessive sneezing		food cravings		mood swings		night waking
	light-headedness		twitching		snoaring		Pica (eating non-food)		head banging		nightmares/terrors
	excessive sweating		blinking		sleep apnea		sensitive to food texture		self-mutilation		difficulty waking
	easy bruising/bleeding		eye pain		hoarsness		canker sores		nail biting		cradle cap
	change in hair growth/loss		excessive tearing		chronic nasal congestion		irregular heartbeat/palpitations		aggressiveness (hitting, biting, etc.)		daytime wetting/soiling
	change in skin/nails		eyes itching		frequent soar throats		nausea/vomiting		rubbing genitals		itchy skin
	balance problem		dark circles under eyes		dry mouth		bloating of abdomen		irritability/tantrums		dry skin
	weakness		visual complaints		grinding teeth		bowel gas		fears/anxieties		other rashes
	faintness		fevers		chest pain		diarrhea		impulsive		warts
	restlessness		nightblindness		difficulty swallowing		constipation		breath holding		molluscum
	swollen glands		hearing complaints		chronic cough		abdominal pain		sensitive to crowds		sensitivity to insect bites

YES		FOR GIRLS			
	nail problems		menses yet?	YES	NO
	frequent diaper rashes		date of first		
			check any symptoms		
				irregular menses	
				cramps	
				heavy bleeding	
				prolonged bleeding (>10 days)	
				premenstrual irritability	

of school days missed this year due to illness: _____

Medication Allergies

My child is allergic to these medications:

Check if none

Current medications

List all prescriptions and over-the-counter medications with dosages:

Vitamins, Herbs and Nutritional Supplements

List all supplements with dosages.

Vaccines

Please attach a copy of your child's immunization record.

Have there been adverse reactions to any vaccines? _____ Please describe: _

Diagnostic Studies

Has your child had any laboratory studies (blood, urine, stool tests, etc.), x-rays or other studies done? _____ Please list and attach copy of results:

Social History

Who lives in the home with your child? _____

Are any children in family adopted? _____ Pets in house? _____
Caregivers besides parents _____

List the people who are most important in your child's life: _____

Recent changes, losses, births, deaths, divorce, remarriage or move? _____

Recent travel? _____

Is your child involved in any sports, music or other activities? _____
Please describe: _____

What exercise does your child get on a regular basis? _____

Time spent watching TV _____ hours per week.
Time spent playing electronic games _____ hours per week.
Child's preferred free-time activities: _____

Our family spends time together regularly in these activities: _____

Do you, your child, or any family members practice any relaxation/stress
management techniques? _____ If yes, Please describe: _____

Developmental History

Please give age when skills were mastered.

Sitting up _____	Running _____	Ride two-wheeler _____
Crawling _____	Jumping _____	Put on clothing _____
Pull to stand _____	Walk down steps _____	First words _____
Walking _____	Pedal _____	Sentences _____

Describe any problems with the above skills: _____

Current school grade _____ Repeated any grades? _____

Class placement: Mainstream _____ Special Ed. _____ Other _____

Describe any Special Education services _____

Dietery / Nutritional History

Breast-fed? Yes No If yes, how long? _____

Bottle-fed? Yes No Began at what age? _____

Brand(s) formula _____

Foods begun at what age? _____

Cow's milk? Yes No Began at what age? _____

Known allergies to food? (list) _____

Suspected allergies to food? (list) _____

Food cravings? (list) _____

Current Foods My Child Eats (place a check mark in appropriate column)

FOODS/BEV-ERAGES	DAILY	3-5 TIMES/WEEK	1-2 TIMES/WEEK	NEVER OR AL-MOST NEVER	USED TO EAT
fresh vegetables					
fresh fruits					
meats/poultry					
fish					
whole grains					
legumes					
bread-white					
bread-whole grain					
pasta					
nuts and seeds					
cookies/cakes					
candy					
milk					
cheese					
yogurt					
ice cream					
salty foods					
chocolate					
caffeine(soda/tea)					
soda					
soy products/milk					

How much water is drunk each day? _____ Fruit juice? _____

Environmental History

CIRCLE THE APPROPRIATE ANSWERS TO THE FOLLOWING QUESTIONS:

Location of home: City / Suburban / Wooded / Farm Other (describe):

Water: City / Well Purification system: Yes / No If other, please describe:

Type of heat: Electric / Gas / Oil / Other If other, please describe:

Do you live near: Power lines / Woods / Industrial areas / Water?

If you live near water, list type: Swamp / River / Ocean / Other If other, please describe:

Does your home have a lot of: Dust / mold / Down or feather items (pillows, upholstery, stuffed animals?)
If so, please give details:

Describe your child's bedroom (circle appropriate response):

Bedding: Synthetic / Down / Feather? Mattress cover? Yes / No Crib/junior bed/adult bed

Flooring: Carpet: Wall-to-wall or area rug? Wood? Glued down? Synthetic pad?

Window treatment: Shades / blinds / thin curtain / heavy curtain / valance / Other?
If other, describe:

Other items in room including furniture, toys, stuffed animals:

Flooring in other rooms:

Child's bathroom

Living room

Family room/play room

Is your child bothered by or sensitive to any of the following? Please check where appropriate and list specific products if possible:

- | | |
|---|---|
| <input type="checkbox"/> Perfumes/cosmetics | <input type="checkbox"/> Mold |
| <input type="checkbox"/> Cleaning products | <input type="checkbox"/> Pollens/grasses |
| <input type="checkbox"/> Soaps | <input type="checkbox"/> Animals (dander) |
| <input type="checkbox"/> Detergents | <input type="checkbox"/> Gasoline |
| <input type="checkbox"/> Dust | <input type="checkbox"/> Paint |
| <input type="checkbox"/> Other | |

Please list known allergies: