Cedar Avenue
INTEGRATIVE MEDICINE

# PATIENT REGISTRATION FORM

Today's Date

## PATIENT INFORMATION

Name: | Date of Birth: | Age:

Gender: ☐ M ☐ F | Marital Status:

Address: | Phone (hm):

City/State/Zip: | Phone (cell):

Email: | May we leave messages at these numbers? ☐ H ☐ C

Preferred method of communication: ☐ Email ☐ Home phone ☐ Cell phone

Emergency Contact: Phone:

Their relationship to you:

For Minors Only: Name of Mother: Name of Father:

**HOW DID YOU HEAR ABOUT US?**

☐ Family/Friend ☐ Insurance ☐ Physician Referral

☐ Internet: Specify ☐ Other:

## BILLING FORMATION

Is patient covered by insurance? ☐ Yes ☐ No | If No, Name of Person Responsible for Bill:

Primary Insurance: | *Address and Phone Number of Responsible Party (if different from above)

(PLEASE GIVE YOUR CARD TO THE RECEPTIONIST)

Subscriber's Name Employer: Occupation: Date of Birth:

Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other:

Subscriber #: Group #:

Secondary Insurance: Subscriber's Name Employer: Date of Birth:

Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other:

Subscriber #: Group #:

☐ By checking this box, I am verifying that the above is true to the best of my knowledge.

Date: _____

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# HEALTH HISTORY QUESTIONNAIRE *For Children*

**All questions contained in this questionnaire are strictly confidential and will become part of your child's medical record.**

| | | |
|---|---|---|
| **Form completed by:** | | **Date:** |
| **Name:** *(Last, First, M.I.)* | ☐ **M** ☐ **F** | **DOB** |
| **PRIMARY CARE PEDIATRICIAN:** | | **Pediatrician Phone #:** |
| **OTHER HEALTHCARE PRACTITIONERS:** Include acupuncturist, chiropractor, massage therapist, medical doctor, nutritionist, osteopath, other specialists etc.: | | |
| **Name:** | **Type of practice:** | **Phone number:** |
| | | |
| | | |
| | | |
| | | |

**Please list your current health concerns for your child in order of their importance to you**

| Concern: | Date of onset: |
|---|---|
| 1. | |
| 2. | |
| 3. | |
| 4. | |
| 5. | |

☐ Yes ☐ No Traumas, Car Accidents, Injuries?

☐ Yes ☐ No Serious Illnesses?

**Surgeries and Hospitalizations:**

| Date | Reason | Hospital |
|---|---|---|
| | | |
| | | |
| | | |

**Has your child ever had a blood transfusion?** ..... ☐ Yes ☐ No

**Child's general state of health is:** ☐ Excellent ☐ Good ☐ Fair ☐ Poor

| | |
|---|---|
| **Date of last physical:** | **Date of last dental exam (if applicable):** |

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| PRENATAL HISTORY | |
|---|---|
| Mother's age at child's birth: | Prenatal care? ☐ No ☐ Yes; with whom?: |
| Difficulty conceiving? ☐ No ☐ Yes; infertility treatments used? | |
| During pregnancy, did the mother experience: | ☐ Bleeding ☐ Drug/Alcohol Abuse ☐ Hypertension ☐ Medications<br>☐ Physical Trauma ☐ Thyroid Problems ☐ Gestational Diabetes<br>☐ Other: |
| During pregnancy, did the mother use any of the following: | ☐ Tobacco ☐ Alcohol ☐ Recreational Drugs ☐ Prescription Drugs<br>☐ Over-the-counter medication ☐ Supplements ☐ Other<br>Please give details: |

| BIRTH HISTORY | | |
|---|---|---|
| **Pregnancy Length:** ☐ On time ☐ Premature _____ wks ☐ Late _____ wks | | |
| **Birth History:** ☐ Vaginal ☐ Cesarean Section ☐ Induced ☐ Forceps ☐Vacuum<br>☐ Trauma, describe:<br>☐ Other: | | |
| **Length of labor:** | **Birth weight:** | **Birth length:** |
| **Any newborn problems?** ☐ Jaundice ☐ Rashes ☐ Seizures ☐ Hospitalization<br>☐ Other, describe | | |

| IMMUNIZATION HISTORY | | | |
|---|---|---|---|
| ☐ Diphtheria: /4 | ☐ Pertussis: /4 | ☐ Tetanus: /4 | ☐ Polio: /4 |
| ☐ Hepatitis B: /3 | ☐ Measles: /2 | ☐ Mumps: /2 | ☐ Rubella: /2 |
| ☐ H. Flu (HiB): /3 | ☐ Tetanus booster: | ☐ Other: | |
| Please indicate any adverse reactions to vaccines: | | | |

| HEALTH & DEVELOPMENT |
|---|
| How was your child's health in the first year? ☐ Poor ☐ Fair ☐ Good ☐ Excellent ☐ Unknown |
| If poor or fair, please describe: |
| At what age did your child first: Sit up Crawl Walk Talk |
| Describe your child's sleep pattern: |

| FEEDING/DIET HISTORY | |
|---|---|
| Breast Fed? ☐ No ☐ Yes; how long? | |
| Formula Fed? ☐ No ☐ Yes; how long? What type? | |
| What foods were introduced before 6 months and at what approximate age? | |
| 6-12 months? | |
| Did your child ever experience colic? ☐ No ☐ Yes; how severe? ☐ mild ☐ moderate ☐ severe | |
| Please list any food allergies or intolerances, along with the reaction they provoke: | |
| What foods does your child crave/insist upon? | |
| Does you child have any dietary restrictions (eg, religious, vegetarian/vegan, etc)? | |
| **Describe your child's typical daily diet:**<br>BREAKFAST: | SNACKS: |
| LUNCH: | LIQUIDS: |
| DINNER: | SWEETS: |

## PAST MEDICAL HISTORY

**Does your child have, or has she/he had:**

| | | | |
|---|---|---|---|
| ☐Yes ☐No | Chicken pox | ☐Yes ☐No | Constipation requiring a doctor visit |
| ☐Yes ☐No | Ear infections | ☐Yes ☐No | Bladder or kidney infection |
| ☐Yes ☐No | Problems with ears or hearing | ☐Yes ☐No | Bed-wetting (if over 5 years old) |
| ☐Yes ☐No | Nasal allergies | ☐Yes ☐No | (girls) Started menstruating? |
| ☐Yes ☐No | Problems with eyes or vision | ☐Yes ☐No | (girls) Any problems with periods? |
| ☐Yes ☐No | Asthma, bronchitis, croup or pneumonia | ☐Yes ☐No | Seizures or other neurologic problems |
| ☐Yes ☐No | Heart problems or murmur | ☐Yes ☐No | Frequent headaches |
| ☐Yes ☐No | Anemia or bleeding problem | ☐Yes ☐No | Chronic or recurrent skin problems |
| ☐Yes ☐No | Frequent abdominal pain | ☐Yes ☐No | Diabetes or thyroid problems |

Has your child had antibiotics? If so, how many times and for what reasons?

## FAMILY HEALTH HISTORY

**Is your child adopted?** ..... ☐ Yes ☐ No

| **Has any family member (or you) been diagnosed with:** | **YES** | **NO** | **Who? At what age?** | **Details** |
|---|---|---|---|---|
| Asthma | ☐ | ☐ | | |
| Emphysema | ☐ | ☐ | | |
| Severe allergies | ☐ | ☐ | | |
| Thyroid problems | ☐ | ☐ | | |
| Stroke/Blood clots | ☐ | ☐ | | |
| Heart disease | ☐ | ☐ | | |
| Heart attack | ☐ | ☐ | | |
| High blood pressure | ☐ | ☐ | | |
| High cholesterol | ☐ | ☐ | | |
| Kidney disease | ☐ | ☐ | | |
| Gallbladder disease | ☐ | ☐ | | |
| Osteoporosis | ☐ | ☐ | | |
| Liver disease | ☐ | ☐ | | |
| Colitis/Crohn's/Celiac | ☐ | ☐ | | |
| Anemia | ☐ | ☐ | | |
| Blood disorder | ☐ | ☐ | | |
| Diabetes | ☐ | ☐ | | |
| Alcohol or drug problems | ☐ | ☐ | | |
| Cancer | ☐ | ☐ | | |
| Mental illness/depression | ☐ | ☐ | | |
| Deafness | ☐ | ☐ | | |
| Developmental disability | ☐ | ☐ | | |
| Bed-wetting after age 10 | ☐ | ☐ | | |
| Other: | ☐ | ☐ | | |

| SOCIAL HISTORY AND DEVELOPMENT |
| --- |
| How would you describe your child's temperament? |
| Is your child in: ☐ School (grade: ) ☐ Daycare ☐ Homecare ☐ Other: |
| What are your child's favorite activities: |
| Does your child exercise regularly? ☐ No ☐ Yes; how much, how often? |
| How much television does your child watch? hrs a ☐ day ☐ week |
| How often does your child read (not for school):<br>☐ Less than weekly ☐ Weekly ☐ Several times a week ☐ Daily |
| How often does someone read to your child:<br>☐ Less than weekly ☐ Weekly ☐ Several times a week ☐ Daily |
| **Home Environment:** |
| How many children in your home? Child's birth order (3rd of 4 kids…) |
| What adults live with your child? |
| Does anyone in the household smoke? ☐ No ☐ Yes, who? |
| Are there animals in the home? ☐ No ☐ Yes, type: |
| How is your child's home heated? |
| Has your child had any traumas or losses? |
| How would you describe the emotional climate of the child's home? |
| **School Age Children:** |
| ☐ Yes ☐ No Has he/she ever been "held back" or had to repeat a grade? |
| ☐ Yes ☐ No Are you concerned about your child's attention span? |
| ☐ Yes ☐ No Does your child like school? |
| ☐ Yes ☐ No Any concerns about your child's behavior in school? |
| ☐ Yes ☐ No Any concerns about how he/she is doing academically? |

| MEDICATIONS | | | |
|---|---|---|---|
| INCLUDE **CURRENT** PRESCRIPTION MEDICATIONS, OVER THE COUNDER DRUGS, VITAMINS, HERBS ETC… | | | |
| Start date | Name & Brand | Dose/ Strength | Frequency |
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| ALLERGIES |
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| Name of Drug, environmental or food allergy Reaction |
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