CENTER FOR HEALING NEUROLOGY

Pediatric Registration

Today's Date: _____

❒New Patient ❒Update Account #:_____

Patient Name (Last, First, M.I.)_____

If patient has ever been known by a different name, list: _____

Home Address: _____City,State,Zip_____

Mailing Address: _____City,State,Zip_____

Home Phone: _____ Cell: _____

E-mail: _____ Birthdate: ____/____/_____ Sex: ❒ M or ❒ F

Register for Patient Portal? ❒ Yes ❒ No

Employer/School Status: ❒ Full-Time ❒ Part-Time Position: _____

Primary Care Physician: _____ Phone: _____

Referring Physician (if applic.): _____ Phone: _____

Family Information:

❒ Spouse/Domestic Partner or ❒ Parent/Guardian #1 Name (Last, First): ❒ M or ❒ F Address: Employer: Phone: Position: How Long:	❒ Parent/Guardian #2 Name (Last, First): ❒ M or ❒ F Address: Employer: Phone: Position: How Long:

If patient is a minor, whom do they live with? ❒ Parent/Guardian #1 ❒ Parent/Guardian #2 ❒ Both ❒ Shared custody

Insurance Information: Is the patient covered by insurance? ❒ Yes or ❒ No

	Primary Insurance	Secondary Insurance	Other Insurance
Insurance Co. Name			
Subscriber Name			
Relationship to Patient			
Subscriber Employer			
Subscr. ID# or SSN			
Group # or Claim #			
Subscriber Birthdate			
Subscriber Address			
Subscriber Phone			

Pediatric Intake Form (continued) Patient Last Name:_____
Date: _____

Preferred Pharmacy:_____ Pharmacy Location: _____
Pharmacy Phone: _____

Medicare Patients Only Check Appropriate Box

❒ Supplemental Insurance is provided by patient
❒ Supplemental Insurance is provided by former employer

Race

❒ American Indian or Alaskan Native ❒ Asian ❒ Black or African American

❒ Native Hawaiian or Other Pacific Islander ❒ White

Ethnicity

Hispanic or Latino? ❒ Yes ❒ No

Preferred Language: _____

Please fill out below if you're here for an on-the-job injury or injury related to an accident:

Is injury job related? ❒ Yes or ❒ No Date of Injury ___/___/_____ Claim # _____

Where did injury occur?_____ Case worker Name/Phone:_____

Briefly describe injury: _____

Emergency Contact (outside of home) First & Last Name _____

Contact's Phone_____ Contact's Relationship to patient: _____

The above information in this two-page Patient Registration Form is true to the best of my knowledge. I understand I am responsible for charges associated with medical services and agree to pay all bills within 30 days from the receipt of statement, unless other arrangements are made.

IF INSURANCE CARD(S) ARE NOT PROVIDED AT THE TIME OF YOUR VISIT, YOU MAY BE BILLED PRIVATELY OR YOUR APPOINTMENT MAY BE RESCHEDULED.

Signature:_____ Date: _____/_____/_____

Patient Last Name:_____

Date: _____

CENTER FOR HEALING NEUROLOGY

Wellness and Health History Questionnaire

Pediatric

Center for Healing Neurology values your privacy. We will keep all your answers confidential. If you don't want to answer a question, feel free to leave it blank.

Current Health Concerns:
Why are we seeing your child today?

Place a checkmark next to any symptom or condition your child currently has:

❒ **My child has none of the symptoms below**

Wellness/Tired ❒	Trouble Seeing ❒	Difficulty Gaining Weight ❒
Fever/Chills ❒	Hoarse Voice ❒	Weight Loss ❒
Seizures ❒	Trouble Breathing ❒	Poor Eating/Drinking ❒
Trouble Sleeping ❒	Wheeze ❒	Eats/Drinks Too Much ❒
Sleeps Too Much ❒	Cough ❒	Pain With Urination ❒
Snoring ❒	Chest Pain ❒	Increased Urination ❒
Headache ❒	Rapid Heart Rate ❒	Blood in Urine ❒
Ear/Throat Pain ❒	Heart Murmur ❒	Vaginal Discharge ❒
Trouble Swallowing/Chewing ❒	Stomach Pain ❒	Irregular/Painful Periods ❒
Neck Pain/Swelling ❒	Constipation ❒	Joint/Leg/Arm Pain ❒
Runny Nose ❒	Vomiting ❒	Easy Bruising ❒
Drainage/Redness ❒	Diarrhea ❒	Yellow Skin/Jaundice ❒
Trouble Hearing ❒	Blood in Stool ❒	Rash/Skin Problems ❒

Is your child allergic to any medications or foods? ❒ Yes ❒ No

If YES, please list:

Patient has Allergies to:	Reaction:

Is your child currently taking any medications or supplements? ❒ Yes ❒ No

If YES, please list:

Medication/Supplement	Dosage	When is it taken?

Patient Last Name:_____

Date: _____

Child's Health History

Was your child born early or on time? ❒On time ❒Early If early, how many weeks early ? _____

Were there any problems in the pregnancy or delivery? ❒No ❒Yes If yes, please describe:

_____

How much did your child weight at birth? _____

How many days did your child stay in the hospital after birth?_____

Has your child ever been hospitalized? ❒No ❒Yes If yes, please describe:

_____

Has your child ever had any operations? ❒No ❒Yes If yes, please describe:

_____

Does your child have any other chronic conditions? ❒No ❒Yes If yes, please describe:

_____

Has your child had any head injury? ❒No ❒Yes

Do you have a primary care provider that handles your child's immunizations? ❒No ❒Yes

Development/School

When did your child… First sit up alone? _____ First walk? _____

Say simple words? _____ Speak in sentences?_____

What grade is your child in? _____What kind of grades does your child get? _____

Does your child receive academic help or developmental therapy? _____

Family History

Circle the condition and identify family members who have any of the following:

Condition	*Family Member*	*Condition*	*Family Member*
Heart Disease/			
High Blood Pressure	_____	Seizures	_____
Stroke	_____	Headaches	_____
Learning Problems	_____	Any other history of	
Problems with movements/ticks	_____	family illnesses or	_____
Stomach or Intestine Disease	_____	early deaths?	_____

Social History

Who lives at home with child? Any stresses at home? _____

❒ Biologic mother ❒ Biologic father

❒ Other: _____ _____

_____ _____

Was the child adopted?_____ Does the child use tobacco/alcohol/other drugs?_____

Patient Education

In what ways do you prefer to learn about how to care for your child's medical needs?

❒ Reading (written materials/pictures) ❒ Listening (one-on-one conversation

❒ Watching (demonstration) ❒ Doing (practicing myself)

Who else helps care for your child? _____

Do you have any needs (physical abilities, cultural, religion) related to your child's care that will help us work together better with your child and family? If so, please explain: _____