



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: ____/____/____

Gender: M F Non-Binary Other Insurance Gender: M F Sex at Birth: M F

Preferred Pronouns: She/Hers He/His They/Theirs Other: _____

Register for Patient Portal? Yes No Marital Status: Single Married Other _____

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

Primary Care Physician: _____ Phone: _____

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

Family Information:

<input type="checkbox"/> Spouse/Domestic Partner or <input type="checkbox"/> Parent/Guardian #1		<input type="checkbox"/> Parent/Guardian #2	
Name (Last, First):		Name (Last, First):	
<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Other _____		<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Other _____	
Address:		Address:	
Employer:	Phone:	Employer:	Phone:
Position:	How Long:	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 Other: _____

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? <input type="checkbox"/> Yes or <input type="checkbox"/> 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: ___/___/_____



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

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?

Pediatric Intake Form (continued)

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:

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

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: _____