



COMPLETE BOTH PAGES  
BLACK INK ONLY

Checked-in: \_\_\_\_\_ Updated: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Sex: M / F  
(First) (MI) (Last)

Address: \_\_\_\_\_  
(Street) (City) (State) (Zip)

Age: \_\_\_\_ D/O/B: \_\_\_\_\_ Social Security #: \_\_\_\_\_

**Guarantor Information** (person financially responsible for patient):

Name: \_\_\_\_\_ D/O/B: \_\_\_\_\_

Address: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_ Marital Status: \_\_\_\_

PHONE: Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

Employer: \_\_\_\_\_

Employer Address: \_\_\_\_\_

Insured's Name (if different than above): \_\_\_\_\_ D/O/B: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Insured's Employer: \_\_\_\_\_ Phone #: \_\_\_\_\_

**Emergency Contact** (person not living with you we may contact in case of emergency):

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone #s: \_\_\_\_\_

Referring Physician: \_\_\_\_\_

Family Physician: \_\_\_\_\_

**Alternate Parent Information:**

Name: \_\_\_\_\_ D/O/B: \_\_\_\_\_

Address: \_\_\_\_\_ Social Security #: \_\_\_\_\_

PHONE: Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

Employer: \_\_\_\_\_ Employer Address: \_\_\_\_\_

**Insurance:**

Primary Insurance: \_\_\_\_\_ Policy Holder: \_\_\_\_\_

Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_ Policy Holder: \_\_\_\_\_

Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

**Auto Insurance** (if due to an accident):

Policy Holder: \_\_\_\_\_ Claim #: \_\_\_\_\_

Company: \_\_\_\_\_ Phone #: \_\_\_\_\_

Address: \_\_\_\_\_

Date of Accident: \_\_\_\_\_ Person handling claim: \_\_\_\_\_

**Do you have an attorney or legal action current or pending for the condition for which you are seeking legal consultation?**

If yes - Name of Attorney: \_\_\_\_\_

Address: \_\_\_\_\_ Phone #: \_\_\_\_\_

Checked-in: \_\_\_\_\_ Updated: \_\_\_\_\_

**Patient Name:** \_\_\_\_\_ **D/O/B:** \_\_\_\_\_

**Height:** \_\_\_\_\_ **Weight:** \_\_\_\_\_ **Birth Weight:** \_\_\_\_\_

**Reason for today's visit:** \_\_\_\_\_

**Complications with pregnancy/delivery:**

Was the baby born prematurely?  No  Yes If yes, how early? \_\_\_\_\_

Did the baby stay in the intensive care?  No  Yes If yes, How long? \_\_\_\_\_

Was the baby on a ventilator  No  Yes If yes, how long? \_\_\_\_\_

Did the baby have any bleeding in the brain?  No  Yes

Any birth trauma: Skull Fracture / Cephalohematoma / Brachioplexus Nerve Injury

At what age did your child start walking? \_\_\_\_\_

Is your child "potty" trained?  No  Yes If yes, at what age: \_\_\_\_\_

**Does your child have any of the following?**

Hydrocephalus?  No /  Yes  Abnormal Head Shape –  Big /  Small

Genetic disorders/syndromes? *Please list:* \_\_\_\_\_

Please list any other **chronic health problems** of your child? \_\_\_\_\_

Please list any **other specialists** who care for your child: \_\_\_\_\_

Past Surgeries &/or Hospitalizations	Date	Complications

**Patient Name:** \_\_\_\_\_

**Current Medications:**

Name of Medication	Dose	Times given

**Medication or other ALLERGIES** \_\_\_\_\_

Allergy to Latex:     No     Yes

Diet:    \_\_\_ Normal for age    \_\_\_ by mouth    \_\_\_ by tube

**Family History:** *Please circle those conditions present in siblings, parents and grandparents*

- High Blood Pressure     Heart Disease     Cancer     Diabetes  
 Liver Disease     Bleeding Problems     Birth Defects     Kidney Disease

*If yes, explain* \_\_\_\_\_

Have you been told your child has any delays in developing skills?     No     Yes

- Motor**     **Speech/Language**     **Social**

*If yes, explain* \_\_\_\_\_

**Patient Name:** \_\_\_\_\_

**Review of Systems:** (conditions or symptoms your child has currently OR had in the past)

**Constitutional**

Unexplained fever ( <b>recent</b> )	Yes	No
Weight loss	Yes	No

**Eyes**

Eyes crossing	Yes	No
Vision loss	Yes	No

**Ear, Nose, Throat & Mouth**

Hearing loss	Yes	No
Trouble swallowing or chewing ( <b>circle one or both</b> )	Yes	No
Choking	Yes	No
Neck pain	Yes	No

**Cardiovascular**

Heart abnormality or defect	Yes	No
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**Respiratory**

Turning blue	Yes	No
Mechanical ventilation – history of / currently use	Yes	No
Tracheostomy – history of / currently use	Yes	No
BPD	Yes	No

**Endocrine**

Growth problems	Yes	No
Excessive thirst or urination	Yes	No

**Integumentary**

Birthmarks	Yes	No
Sacral or other spine dimple	Yes	No

**Gastrointestinal**

Stomach reflux	Yes	No
Constipation	Yes	No
Bowel incontinence	Yes	No
Feeding tube	Yes	No

**Patient Name:** \_\_\_\_\_

**Musculoskeletal**

Back pain	Yes	No
Arm pain	Yes	No
Arm numbness	Yes	No
Leg pain	Yes	No
Leg numbness	Yes	No
Scoliosis	Yes	No

**Genitourinary**

Kidney or urinary infections	Yes	No
Bladder reflux	Yes	No
Urinary incontinence	Yes	No
Urethral straight catheterization (non-balloon)	Yes	No

**Neurological**

Headaches	Yes	No
Dizziness	Yes	No
Seizures	Yes	No

**Hematologic/Lymphatic**

Bleeding tendencies/Hemophilia/Clotting disorder	Yes	No
Anemia	Yes	No

**Social Development**

Problems in school/preschool/daycare	Yes	No
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**Form completed by:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Relationship to child:** \_\_\_\_\_