PATIENT INFORMATION

PATIENT NAME ________________________________ DOB____________________ PRONOUN _______

PARENT(S)' NAME(S) __________________________________ / __________________________________

ADDRESS ____ CITY ______________________ ZIP _______

TELEPHONE ___________________________ E-MAIL____

CHILD'S SCHOOL ____GRADE _______________________

CHILD'S PHYSICIAN __________________________________ TELEPHONE ________________________

WHO MAY WE THANK FOR REFERRING YOU? ____

What condition would you like to have treated? ____

How long has your child had this condition? ____

Have they been treated for this condition? If so, please explain ______________________________________

YOUR CHILD'S MEDICAL HISTORY

○ Allergies ○ Asthma ○ Diabetes ○ Epilepsy ○ Skin Conditions/Eczema ○ Digestive Disorders
○ Recurrent Ear Infections ○ Other ____

○ Does your child have any food allergies? Y / N. If so, which foods? _____________________________

○ Surgery/Hospitalizations (list) ____
○ Medications/Supplements (list) ____

How many hours does your child sleep at night? ○ 8 ○ 9 ○ 10 ○ 11 ○ 12 or more
Does your child nap? Y N If yes, total duration of nap(s) _________ hours

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PARENT MEDICAL HISTORY

○ Allergies ○ Arthritis ○ Alzheimer's ○ Cancer ○ Depression ○ Diabetes ○ Headaches ○ Heart Disease ○ Migraines ○ Osteoporosis ○ Stroke
○ Other ____

Parent's Signature ____ Date ______________________