PATIENT INFORMATION

PATIENT NAME _____ DATE OF BIRTH_____ M / F

PARENT(S)' NAME(S) _____ / _____

ADDRESS _____ CITY _____ ZIP _____

HOME PHONE _____ CELL/WORK PHONE _____

E-MAIL ADDRESS _____

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? _____

Has he/she 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 _____