Cedar Avenue
INTEGRATIVE MEDICINE

PATIENT REGISTRATION FORM

Today's Date

PATIENT INFORMATION

Name: | Date of Birth: | Age:

Gender: ☐ M ☐ F | Marital Status: Choose

Address: | Phone (hm):

City/State/Zip: | Phone (cell):

Email: | May we leave messages at these numbers? ☐ H ☐ C

Preferred method of communication: ☐ Email ☐ Home phone ☐ Cell phone

Emergency Contact: Phone:

Their relationship to you:

For Minors Only: Name of Mother: Name of Father:

HOW DID YOU HEAR ABOUT US?

☐ Family/Friend ☐ Insurance ☐ Physician Referral

☐ Internet: Specify ☐ Other:

BILLING FORMATION

Is patient covered by insurance? ☐ Yes ☐ No | If No, Name of Person Responsible for Bill:

Primary Insurance: | *Address and Phone Number of Responsible Party (if different from above)

(PLEASE GIVE YOUR CARD TO THE RECEPTIONIST)

Subscriber's Name Employer: Occupation: Date of Birth:

Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other:

Subscriber #: Group #:

Secondary Insurance: Subscriber's Name Employer: Date of Birth:

Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other:

Subscriber #: Group #:

☐ By checking this box, I am verifying that the above is true to the best of my knowledge.

Date: _____

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HEALTH HISTORY QUESTIONNAIRE *For Children*

All questions contained in this questionnaire are strictly confidential and will become part of your child's medical record.

Form completed by:		**Date:**
Name: *(Last, First, M.I.)*	☐ **M** ☐ **F**	**DOB**
PRIMARY CARE PEDIATRICIAN:		**Pediatrician Phone #:**
OTHER HEALTHCARE PRACTITIONERS: Include acupuncturist, chiropractor, massage therapist, medical doctor, nutritionist, osteopath, other specialists etc.:		
Name:	**Type of practice:**	**Phone number:**

Please list your current health concerns for your child in order of their importance to you

Concern:	Date of onset:
1.	
2.	
3.	
4.	
5.	

☐ Yes ☐ No Traumas, Car Accidents, Injuries?

☐ Yes ☐ No Serious Illnesses?

Surgeries and Hospitalizations:

Date	Reason	Hospital

Has your child ever had a blood transfusion? ..... ☐ Yes ☐ No

Child's general state of health is: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Date of last physical:	**Date of last dental exam (if applicable):**

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PRENATAL HISTORY	
Mother's age at child's birth:	Prenatal care? ☐ No ☐ Yes; with whom?:
Difficulty conceiving? ☐ No ☐ Yes; infertility treatments used?	
During pregnancy, did the mother experience:	☐ Bleeding ☐ Drug/Alcohol Abuse ☐ Hypertension ☐ Medications ☐ Physical Trauma ☐ Thyroid Problems ☐ Gestational Diabetes ☐ Other:
During pregnancy, did the mother use any of the following:	☐ Tobacco ☐ Alcohol ☐ Recreational Drugs ☐ Prescription Drugs ☐ Over-the-counter medication ☐ Supplements ☐ Other Please give details:

BIRTH HISTORY		
Pregnancy Length: ☐ On time ☐ Premature _____ wks ☐ Late _____ wks		
Birth History: ☐ Vaginal ☐ Cesarean Section ☐ Induced ☐ Forceps ☐Vacuum ☐ Trauma, describe: ☐ Other:		
Length of labor:	**Birth weight:**	**Birth length:**
Any newborn problems? ☐ Jaundice ☐ Rashes ☐ Seizures ☐ Hospitalization ☐ Other, describe		

IMMUNIZATION HISTORY			
☐ Diphtheria: /4	☐ Pertussis: /4	☐ Tetanus: /4	☐ Polio: /4
☐ Hepatitis B: /3	☐ Measles: /2	☐ Mumps: /2	☐ Rubella: /2
☐ H. Flu (HiB): /3	☐ Tetanus booster:	☐ Other:	
Please indicate any adverse reactions to vaccines:			

HEALTH & DEVELOPMENT
How was your child's health in the first year? ☐ Poor ☐ Fair ☐ Good ☐ Excellent ☐ Unknown
If poor or fair, please describe:
At what age did your child first: Sit up Crawl Walk Talk
Describe your child's sleep pattern:

FEEDING/DIET HISTORY	
Breast Fed? ☐ No ☐ Yes; how long?	
Formula Fed? ☐ No ☐ Yes; how long? What type?	
What foods were introduced before 6 months and at what approximate age?	
6-12 months?	
Did your child ever experience colic? ☐ No ☐ Yes; how severe? ☐ mild ☐ moderate ☐ severe	
Please list any food allergies or intolerances, along with the reaction they provoke:	
What foods does your child crave/insist upon?	
Does you child have any dietary restrictions (eg, religious, vegetarian/vegan, etc)?	
Describe your child's typical daily diet: BREAKFAST:	SNACKS:
LUNCH:	LIQUIDS:
DINNER:	SWEETS:

PAST MEDICAL HISTORY

Does your child have, or has she/he had:

☐Yes ☐No	Chicken pox	☐Yes ☐No	Constipation requiring a doctor visit
☐Yes ☐No	Ear infections	☐Yes ☐No	Bladder or kidney infection
☐Yes ☐No	Problems with ears or hearing	☐Yes ☐No	Bed-wetting (if over 5 years old)
☐Yes ☐No	Nasal allergies	☐Yes ☐No	(girls) Started menstruating?
☐Yes ☐No	Problems with eyes or vision	☐Yes ☐No	(girls) Any problems with periods?
☐Yes ☐No	Asthma, bronchitis, croup or pneumonia	☐Yes ☐No	Seizures or other neurologic problems
☐Yes ☐No	Heart problems or murmur	☐Yes ☐No	Frequent headaches
☐Yes ☐No	Anemia or bleeding problem	☐Yes ☐No	Chronic or recurrent skin problems
☐Yes ☐No	Frequent abdominal pain	☐Yes ☐No	Diabetes or thyroid problems

Has your child had antibiotics? If so, how many times and for what reasons?

FAMILY HEALTH HISTORY

Is your child adopted? ..... ☐ Yes ☐ No

Has any family member (or you) been diagnosed with:	YES	NO	Who? At what age?	Details
Asthma	☐	☐		
Emphysema	☐	☐		
Severe allergies	☐	☐		
Thyroid problems	☐	☐		
Stroke/Blood clots	☐	☐		
Heart disease	☐	☐		
Heart attack	☐	☐		
High blood pressure	☐	☐		
High cholesterol	☐	☐		
Kidney disease	☐	☐		
Gallbladder disease	☐	☐		
Osteoporosis	☐	☐		
Liver disease	☐	☐		
Colitis/Crohn's/Celiac	☐	☐		
Anemia	☐	☐		
Blood disorder	☐	☐		
Diabetes	☐	☐		
Alcohol or drug problems	☐	☐		
Cancer	☐	☐		
Mental illness/depression	☐	☐		
Deafness	☐	☐		
Developmental disability	☐	☐		
Bed-wetting after age 10	☐	☐		
Other:	☐	☐		

SOCIAL HISTORY AND DEVELOPMENT
How would you describe your child's temperament?
Is your child in: ☐ School (grade:) ☐ Daycare ☐ Homecare ☐ Other:
What are your child's favorite activities:
Does your child exercise regularly? ☐ No ☐ Yes; how much, how often?
How much television does your child watch? hrs a ☐ day ☐ week
How often does your child read (not for school): ☐ Less than weekly ☐ Weekly ☐ Several times a week ☐ Daily
How often does someone read to your child: ☐ Less than weekly ☐ Weekly ☐ Several times a week ☐ Daily
Home Environment:
How many children in your home? Child's birth order (3rd of 4 kids…)
What adults live with your child?
Does anyone in the household smoke? ☐ No ☐ Yes, who?
Are there animals in the home? ☐ No ☐ Yes, type:
How is your child's home heated?
Has your child had any traumas or losses?
How would you describe the emotional climate of the child's home?
School Age Children:
☐ Yes ☐ No Has he/she ever been "held back" or had to repeat a grade?
☐ Yes ☐ No Are you concerned about your child's attention span?
☐ Yes ☐ No Does your child like school?
☐ Yes ☐ No Any concerns about your child's behavior in school?
☐ Yes ☐ No Any concerns about how he/she is doing academically?

MEDICATIONS			
INCLUDE **CURRENT** PRESCRIPTION MEDICATIONS, OVER THE COUNDER DRUGS, VITAMINS, HERBS ETC…			
Start date	Name & Brand	Dose/ Strength	Frequency

ALLERGIES
Name of Drug, environmental or food allergy Reaction