Patient Registration

(Please Print)

Date:

DEMOGRAPHICS

Last Name: First Name: M.I.:	D.O.B.: Age: Sex: M or F
Social Security Number:	Ethnicity: Race: Language:
Street Address:	City, State, Zip
Is Patient: Biological Adopted(date of adoption________) Foster(beginning foster date __________)	Home Phone: Mobile Phone:
Patient lives with: Birth Parents Foster Parents Adoptive Parents Parent/Step-parent One Parent Other______________	Communication Preference: Mobile Home Email
Diagnosis from Pediatrician:	Emergency Contact Name: Phone Number:
Email Address:	Emergency Contact Relationship to Patient:
Guardian Name (Last, First):	Guardian Name (Last, First):

PRIMARY CARE PHYSICIAN

Primary Care Physician:	Facility:
Phone Number:	Fax Number:

PRIMARY INSURANCE

Insurance Company:	Provider Phone Number:
Subscriber Name:	Relationship to Insured:
Subscriber SSN:	Subscriber DOB:
Group Number:	Policy Number:

SECONDARY INSURANCE

Insurance Company:	Provider Phone Number:
Subscriber Name:	Relationship to insured:
Subscriber SSN:	Subscriber DOB:
Group Number:	Policy Number:

Patient Name:
D.O.B: Age:

MEDICAL HISTORY

Has the patient had any of the following? (If yes, please indicate date and/or what occurred):

Y	N	Chronic Ear Infections:	Y	N	Seizures:
Y	N	Difficulty Passing Urine/Stool:	Y	N	High Fevers:
Y	N	Asthma:	Y	N	Allergies:
Y	N	Frequent Colds/Infections:	Y	N	Vision Difficulty: Glasses? Y or N
Y	N	Surgery/Hospitalization:	Y	N	Hearing Difficulty:
Y	N	Unusual Illness:	Y	N	Tubes in Ears:
Y	N	Serious Accidents:	Y	N	Coordination Problems:
Y	N	Medical Precautions? (Please explain)			

Adaptive equipment needs: (hand splint, AFO, glasses, wheelchair, oxygen, hearing aids, other): ____
Recent dental work? (Cleanings, extractions, etc.) ____
Please list any allergies: ____
Please list current medications: ____

PRENATAL HISTORY

Y	N	Any difficulty during pregnancy?	Length of pregnancy (in weeks):
Y	N	Did mother take any medications and/or drugs during pregnancy?	Did mother receive prenatal care?
Y	N	Did mother smoke or use alcohol during pregnancy?	
Y	N	Any difficulty during delivery?	After delivery?
Y	N	Premature birth?	
Y	N	NICU?	

Type of birth: Vaginal Cesarean

DEVELOPMENTAL HISTORY

What grade is the patient in?____________________________
What does the patient like to do? ____________________________
What does the patient have difficulty doing? ____________________________

When did your Patient begin the following?

Sitting without support	< 5 mos.	5 – 8 mos.	> 8 mos.
Crawling on hands and knees	< 6 mos.	6 – 9 mos.	> 9 mos.
Walking unassisted	< 10 mos.	10 – 18 mos.	> 18 mos.
Saying first few words	< 10 mos.	10 – 16 mos.	> 16 mos.
Talking in simple sentences	< 15 mos.	15 – 36 mos.	> 36 mos.
Staying dry during the day	< 24 mos.	24 – 40 mos.	> 40 mos.

Has your Patient received therapy in the past?
If so, please write date of last visit or current.

Therapy	**Home**	**Clinic**	**School**
Occupational			
Speech			
Feeding			
Physical			

Behavioral Characteristics/Temperament:
____