CHILD REGISTRATION

Doctor Pia | Your Health and Wellness Doctor

❶ ABOUT THE CHILD

Last Name: | First Name: | MI | Date of Birth: | Age: | Social Security Number:

Mailing Address: | Height: | Weight: | Sex: ☐ Male ☐ Female

City, State, Zip Code: | Best Way to Reach You: ☐ Home ☐ Cell ☐ Work | Preferred Phone: ( )

❷ ABOUT THE PARENT

Last Name: | First Name: | MI | Home Phone: ( ) | Cell Phone: ( )

Address: ☐ Same as Above | Mailing Address: | City, State, Zip Code:

Employer Name: | Job Title: | Work Phone: ( )

Employer Address: | Employer City, State, Zip Code:

❸ VACCINATIONS/MEDICATIONS

Have you chosen to vaccinate your child? ☐ Yes ☐ No

If yes, check all that your child has received: ☐ DPT ☐ MMR ☐ Chicken Pox ☐ Hepatitis ☐ Other

Any reactions to vaccines? ☐ Yes ☐ No

Does your child take medications? ☐ Yes ☐ No

Does Your Child Take Vitamins or Herbs? ☐ Yes ☐ No

If Yes, List or ☐ See Attached

❹ NATURAL HEALTH CARE EXPERIENCE

Who referred you to our office?

Have you seen or heard of our office because of (check all that apply)? ☐ Family ☐ Friend ☐ Health Care Professional ☐ Web ☐ Other

Has your child been seen by a natural health doctor before? ☐ Yes ☐ No

If yes, what was the reason for those visits?

Doctor's Name:

Approximate date of last visit:

❺ REASON FOR THIS VISIT

Describe the reason for this visit: ☐ Wellness ☐ Condition

Is the purpose of this visit related to: ☐ Digestion/Diet ☐ Behavior ☐ Sports

When did this condition begin?

Please describe your concerns:

Has this condition: ☐ Gotten Worse ☐ Stayed Constant ☐ Come and Gone

Does this condition interfere with: ☐ Sleep ☐ Daily Routine ☐ Other Activities

Has the condition occurred before? ☐ Yes ☐ No

Did your child receive treatment? ☐ Yes ☐ No

Name of doctor:

Result:

❼ PAYMENT AND INVOICING (payment is due at the time of service)

☐ Would you like a copy of your invoice emailed to you for you to submit to your insurance company?

☐ I understand that I must provide 24 hours notice to cancel or reschedule an appointment, and that if I do not, charges will still apply.

The information provided on this form is true to the best of my knowledge, and I will inform you of any changes in my health, demographics or insurance when applicable. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize this office or my insurance company to release information required to process my claims and that, otherwise, it will be kept confidential in accordance with state law.

Guardian Signature: | Date: | Email:

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❽ PRENATAL HISTORY

During pregnancy, did you use: ☐ Drugs/Medications ☐ Tobacco/Alcohol
If yes, please explain:

Location of birth:
☐ Home ☐ Birthing Center ☐ Hospital

Describe your delivery:
☐ Labor was chemically induced ☐ C-section delivery ☐ Doctor pulled or twisted baby
☐ Labor was doctor-assisted ☐ Forceps/Vacuum extraction ☐ Premature delivery
Please explain:

How long was labor from the first regular contractions to the birth?
How long was the 2nd stage (pushing phase) of labor?

Describe any complications experienced during delivery:

Did you experience any illness(es) while pregnant? Please explain.
☐ Yes ☐ No

Describe any genetic conditions or disabilities:

Birth weight:	Birth length:	Apgar score at 1 min: /10	Apgar score at 5 min: /10	Ultrasound during pregnancy? Yes ☐ No ☐	If yes, how many?

Did you breastfeed the baby? ☐ Yes ☐ No
If yes, how long?
Did you formula feed the baby? ☐ Yes ☐ No
If yes, how long?

At what age did you introduce solids?
At what age did you introduce cows milk?
Are you aware if any juice allergies or food intolerances? ☐ Yes ☐ No

❾ CHILD'S CURRENT HEALTH STATUS

Has your child ever taken antibiotics ☐ Yes ☐ No
If yes, please explain:

Has your child ever been hospitalized? ☐ Yes ☐ No
If yes, please explain:

The National Safety Council reports approximately 50% of children fall head-first from a high place during their first year of life. (i.e. bed, changing table, stairs, etc). Was this the case for your child? If yes, please explain.
☐ Yes ☐ No

Has your child ever been in a car accident? ☐ Yes ☐ No
If yes, please explain:

Has your child ever had surgery? ☐ Yes ☐ No
If yes, please explain:

Does your child have trouble interacting with others? ☐ Yes ☐ No
If yes, please explain:

Have you or anyone else noticed that your child is nervous, twitches, shakes or exhibits rocking behavior
☐ Yes ☐ No If yes, please explain:

What changes (if any) in your child's health or behavior would you like to accomplish?

❿ CHILD'S HEALTH HISTORY

Instructions: Please check each of the diseases or conditions that the child now or has had in the past. While they may seem unrelated to the purpose of the appointment, they can affect the overall diagnosis, care plan and the possibility of being accepted for care.

☐ Acid Reflux	☐ Bed Wetting	☐ Constipation	☐ Difficult Weight Gain	☐ Frequent Colds, Coughs	☐ Learning Disorders
☐ Asthma	☐ Colic	☐ Diarrhea	☐ Ear Infections	☐ Hyperactivity	☐ Sleeping Difficulties