

Minor/Child Registration

Date _____

(Please print)

Name of Minor/Child _____

Home Address _____

Last Name

First Name

Initial

Street

City

State

Zip

Home Phone _____ Parent/Guardian Work Phone _____

Birth Date _____ Age _____ Sex: M F Social Security Number _____

Personal Financially Responsible _____

Whom may we thank for referring you? _____

CHIEF COMPLAINT _____

Birth History

Hospital _____ Obstetrician _____

Type of Delivery _____ Birth Weight _____ Birth Length _____

Complications _____

List Age: Cooed or Laughed _____ Sat _____ First Word _____

Held Head Up _____ Walked _____ Toilet Trained _____

Health History

Minor Child's Physician _____ City/State _____ Phone _____

Date of Last Physical Examination _____ Results _____

Is Minor/Child under care of physician now? _____

Receiving any medication or drugs? _____ Medications _____

Has your child been hospitalized? _____

Date

Reason

Hospital

Allergies _____

Health History

Has minor/child had any history of, or difficulty with, any of the following:

Yes	No		Yes	No		Yes	No	
___	___	AIDS/HIV	___	___	Chicken Pox	___	___	Heart Problems
___	___	Anemia	___	___	Constipation	___	___	Hepatitis
___	___	Asthma	___	___	Convulsions	___	___	Kidney Disease
___	___	Bed Wetting	___	___	Diabetes	___	___	Lead Poisoning
___	___	Bladder Problems	___	___	Drug/Alcohol Abuse	___	___	Liver Disease
___	___	Bleeding, Excessive	___	___	Ear Infections	___	___	Measles
___	___	Cancer	___	___	Epilepsy	___	___	Mononucleosis
___	___	Cerebral Palsy	___	___	Fainting	___	___	Mumps
___	___	Birth Defects	___	___	Hearing Problems	___	___	Pneumonia
___	___	Rheumatic Fever	___	___	Sinus Problems	___	___	Speech Problems
___	___	Thyroid Fever	___	___	Tuberculosis	___	___	Urinary Disease
___	___	Vision Problems	___	___	Worms			

Other _____

Immunizations

Check whether or not your mind/child has been given the following immunizations. If yes, please fill in with date given.

Yes	No	Date		Yes	No	Date	
___	___	_____	DPT Series of 3 Shots	___	___	_____	Mumps Vaccine
___	___	_____	DPT Booster Shots	___	___	_____	Polio Series of 3
___	___	_____	Rubella Vaccine	___	___	_____	Polio Booster
___	___	_____	Diphtheria Tetanus	___	___	_____	Polio (by mouth), Series of 3
___	___	_____	Hepatitis B	___	___	_____	Measles Vaccine
___	___	_____	Tuberculin Test				
		_____	Results _____				

Family History

Has nay member of the family or close relative had:

Yes	No		Yes	No		Yes	No	
___	___	Arthritis	___	___	Diabetes	___	___	Mental Illness
___	___	Asthma or Hay Fever	___	___	Hemophilia Bleeder	___	___	Migraine
___	___	Cancer	___	___	High Blood Pressure	___	___	Tuberculosis
___	___	Chemical Dependency	___	___	Kidney Disease			
___	___	Convulsions of Epilepsy	___	___	Heart Disease	Other	_____	

In the event of an emergency, who should we contact?

Name	Relationship	Phone
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