

Phone 269-254-8130 | Fax 866-376-0467

www.santoshawellnesskzoo.com

**Patient Information**

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| --- |
| Name: |
| Birthdate (mm/dd/yyyy): | Sex: ( ) Male ( ) Female  |
| Diagnosis:  |
| Physician Name: |
| Physician Office: |
| Reason for Referral:  |
| Would you like to receive text/email appointment reminders? ( ) Yes ( ) NoIf yes, provide your preferred number/email:  |

**Parent/Caregiver Information**

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| Parent #1: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ( ) Mom ( ) Dad ( ) Foster Parent ( ) Other \_\_\_\_\_\_\_\_\_Parent #2: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ( ) Mom ( ) Dad ( ) Foster Parent ( ) Other \_\_\_\_\_\_\_\_\_ |
|  Is your child adopted? ( ) Yes ( ) No  | Who does the child live with?: \_\_\_ Parent #1 \_\_\_ Parent #2 \_\_\_ Both Please explain the living situation (*if not living with both parents):*  |
| Address:  |
| Preferred Phone: Name:  |
| Alternate Phone: Name: |
| Preferred Email: |

**Emergency Contact Information**

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| Name: |
| Address:  |
| Phone: |
| Relationship to Patient:  |

**Medical History**

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| Major Illnesses (if any): ( ) Ear Infections (how often? \_\_\_\_\_\_ what treatment? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)( ) Seizures (how often? \_\_\_\_\_\_ what treatment? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) |
| Hospitalizations (if any):  |
| Surgeries (with dates):( ) Ear Tubes \_\_\_\_\_\_\_\_\_ ( ) Central Line \_\_\_\_\_\_\_\_\_ ( ) G-Tube \_\_\_\_\_\_\_\_\_ ( ) Heart Repair \_\_\_\_\_\_\_\_\_ ( ) Trach \_\_\_\_\_\_\_\_\_ ( ) Shunt \_\_\_\_\_\_\_\_\_( ) Tonsillectomy \_\_\_\_\_\_\_\_\_ ( ) Adenoidectomy \_\_\_\_\_\_\_\_\_ ( ) Frenulectomy \_\_\_\_\_\_\_\_\_( ) Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Allergies: ( ) Yes ( ) NoIf yes, please list: |
| Current Medications (list medication, dosage, and reason):  |
| Has your child ever received services (ie. OT, PT, SLP, Earn On, IEP/504)? ( ) YES ( ) NOIf yes, what services and when:  |

**Educational History**

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| What school does your child attend? |
| Grade:  | How often does he/she attend: \_\_\_\_\_ days per week \_\_\_\_\_ hours per day  |
| What are your child’s strengths in school?  |
| What areas at school are the most difficult for your child? |

**Please share any specific concerns you would like to share with us regarding your child:**

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**What is your main goal for your child?**

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*Thank you for taking the time to complete this form!*