

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

www.santoshawellnesskzoo.com

**Patient Information**

|  |  |
| --- | --- |
| 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 ( ) No  If yes, provide your preferred number/email: | |

**Parent/Caregiver Information**

|  |  |
| --- | --- |
| 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 ( ) No  If 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 ( ) NO  If 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!*