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

Name:
Address:
Phone:
Relationship to Patient:

Additional Contacts for Care Coordination

Care Provider	*Contact Information (name, email, phone #)*
Primary Physician	
Psychology	
Teacher	
Case Manager	
Other	

Pregnancy

Complications during labor/delivery:

( ) NONE ( ) C-Section ( ) Emergency ( ) Forceps ( ) Vacuum

( ) Other _____

Complications/Health problems during pregnancy:

( ) NONE ( ) Diabetes ( ) Toxemia ( ) Strep ( ) Premature Labor

( ) Other _____

Medications during pregnancy: ( ) Yes ( ) No

If yes, please list _____

_____

Drug/Alcohol use during pregnancy: ( ) Yes ( ) No

If yes, please list _____

_____

Birth Information

Birth Weight: _____lbs _____oz	Gestational Age at Birth:
APGAR:	

Condition After Birth

( ) Full-Term ( ) Pre-mature ( ) NICU Stay (If yes, duration: _____)

( ) Oxygen ( ) Jaundice ( ) Heart Problems ( ) Feeding Tube

( ) Congenital Abnormalities (If yes, please explain _____

_____)

Other _____

Any Testing Completed _____

_____

Medical History

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:

Tests Performed (if yes, please list date):

( ) MRI _____ ( ) CT Scan _____ ( ) Genetic Testing _____

( ) X-Rays _____ ( ) Other_____

Current Medications (list medication, dosage, and reason):

Has your child ever had a vision test? ( ) YES ( ) NO

If yes, date _____ and results _____

Does your child wear glasses? ( ) YES ( ) NO

Has your child ever had a hearing test? ( ) YES ( ) NO

If yes, date _____ and results _____

Does your child wear a hearing aid? ( ) YES ( ) NO

If yes, please indicate: ( ) LEFT ( ) RIGHT

Has your child ever received services or additional supports (ie. OT, PT, Speech, Early On, IEP/504, tutoring in school, Special Education classroom, Resource Room, pull out groups in school)? ( ) YES ( ) NO

If yes, please list all and explain:

Is your child aware of the problem?

Developmental History

Please list the approximate age your child accomplished the following and write any pertinent details:

Motor			
Lift head while on tummy		Crawled (Indicate Hand/Knee or Belly)	
Rolled over		Stood independently	
Sat independently		Walked independently	

Self-Care			
Dress/Undress self			
Button/zip clothes	( ) Yes ( ) No	Tie shoes	( ) Yes ( ) No
Potty trained - DAY	( ) Yes ( ) No	Potty trained – NIGHT	( ) Yes ( ) No
Sleep Hygiene	Sleeps through the night ( ) Yes ( ) No How many hours? _____ Where does child sleep? _____ Do they have a set bedtime routine? ( ) Yes ( ) No Does their routine include technology (ie. iPad)? ( ) Yes ( ) No Does anything specific help them sleep at night? ( ) Yes ( ) No If yes, please explain: _____ _____		
Grooming	Tooth brushing: ( ) Independent ( ) Needs Help ( ) Dependent Hair brushing: ( ) Independent ( ) Needs Help ( ) Dependent Washing face: ( ) Independent ( ) Needs Help ( ) Dependent Personal Hygiene: ( ) Independent ( ) Needs Help ( ) Dependent *Please explain if needs help or dependent:*		
Bathing	**Bath** ( ) Yes ( ) No **Shower** ( ) Yes ( ) No **Tolerates well:** ( ) Yes ( ) No Washes hair: ( ) Independent ( ) Needs Help ( ) Dependent Washes body: ( ) Independent ( ) Needs Help ( ) Dependent *Please explain if needs help or dependent:*		
Any bowel/bladder difficulties? ( ) Yes ( ) No If yes, please explain:			

Is your child able to identify the following feelings?

( ) Needing to use the bathroom ( ) Tired

( ) Hungry ( ) Pain

( ) Thirsty ( ) Feeling hot/cold

How do your child handle pain?

( ) normal response ( ) Over-reacts ( ) Under-reacts

Please explain:

Started solid foods	
Used eating utensils	
Drank from open cup	
Mealtime Participation	Sits through family meal ( ) Yes ( ) No Uses technology at the table ( ) Yes ( ) No Eats family foods ( ) Yes ( ) No

Any feeding/mealtime difficulties? YES NO
If yes, please explain (ie. gagging, choking, difficulty swallowing, reflux/vomiting, very picky eater…)

Does your child have a history of any trauma (*physical, sexual, emotion, neglect, medical*)? ( ) Yes ( ) No

If yes, please explain:

Social Emotional – *describe how you child does in the following situations*	
Play well with others	
Follows directions	1-step directions: ( ) Yes ( ) No 2-step directions: ( ) Yes ( ) No 3+ step directions: ( ) Yes ( ) No
Develops peer relationships	Does your child make friends easily? ( ) Yes ( ) No *If no, please explain:*

Play skills	*Please describe your child's play skills:* Favorite toys: Do they use their imagination in play? Do they play well with others? (ie. Sharing, engaging in an activity with another child) Are there any activities they avoid? Do they enjoy social activities (ie. library story time, birthday parties)?
Controls emotions well	Frustration: Anger: Excitement: What strategies (if any) help your child calm down? Is your child able to identify their emotions?

Educational History

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?	
Has your child ever been suspended or expelled from a school? ( ) Yes ( ) No *If yes, please explain:*	

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

What goal would you like your child to work on while with us?

Thank you for taking the time to complete this form!