SANTOSHA
WELLNESS

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:

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:
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

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:

What is your main goal for your child?

Thank you for taking the time to complete this form!