Dr. Renee Bonin & Associates

Patient Registration Today's Date: _____

Patient's Full Name: _____Birthdate:_____

Spouse's Name (if applicable):_____Birthdate:_____

Parent's Name (if applicable):_____Birthdate:_____

Patient's Address: _____

City, State, Zip: _____

Patient's Marital Status: ___Single ___Married ___Separated ___Divorced ___Widowed

Patient: ___Male ___Female Employer/School & Phone: _____

Patient SS#(if 18 years or older) or parents SS#: _____

Home Phone: _____ Cell Phone: _____

Referred by: _____

Reason for Appointment: _____

Veteran: ___ Yes ___ No Ethnicity: _____ Religion: _____

Primary Physician: _____ Phone: _____

Pharmacy: _____ Phone: _____

Email Address: _____

Emergency Contact Name & Phone Number: _____

Appointment Reminder: ___Phone Message ___E-mail

INSURANCE

Primary Insurance: _____ Member ID#: _____

Name of Insured: _____ Birthdate: _____

Insured's SS#: _____

Insurance Company Phone #: _____ Group#: _____

Secondary Insurance: _____ Member ID#: _____

Name of Insured: _____ Birthdate: _____

Insured's SS#: _____

Insurance Company Phone #: _____ Group#: _____

Patient History

Please fill out this form to the best of your knowledge. If some questions are not applicable to you or your child, write N/A. If you need more space or wish to make additional comments, please write on the back or attach a separate sheet.

DEMOGRAPHIC INFORMATION:

Date: _____

Form Completed by: _____ Relationship to child: _____

Home Phone: _____ Work Phone: _____

Address: _____

Language(s) other than English spoken in home: _____

Child's Name: _____
First *Middle* *Last*

Gender: □ Male □ Female Date of birth: _____ Age: _____ Current Grade: _____

REFERRAL SOURCE:

Why are you seeking help for your child? _____
_____
_____

Who referred you? _____

What kind of services are you seeking for your child? _____
_____

SERVICES / INTERVENTION SOUGHT PREVIOUSLY:

□ Medical Evaluation □ Neuropsychological Assessment □ Educational Testing □ Psychiatric Exam

□ Medication □ Neurological Exam □ Speech language service □ Special Education

□ School Modification □ Psychological counseling or therapy □ Occupational/Physical Therapy □ Tutoring

□ Other (Specify) _____

MEDICATIONS:

MEDICATION	DOSAGE	FREQUENCY

MEDICAL AND DEVELOPMENTAL HISTORY:

PRE-NATAL HISTORY:
Please answer which of the following conditions may have occurred during this pregnancy and explain (month, amount, treatment) in the space below:

Yes	No		Yes	No	
☐	☐	Edema (swelling of the hands and feet)	☐	☐	Fever
☐	☐	Vaginal Bleeding	☐	☐	Accidents
☐	☐	Toxemia	☐	☐	Medications Used
☐	☐	Emotional Stress	☐	☐	Forceps used
☐	☐	High Blood Pressure	☐	☐	Breech position
☐	☐	Infections (colds, flu, urinary tract)	☐	☐	Induced labor
☐	☐	Injuries	☐	☐	Caesarean Delivery
☐	☐	Preterm Labor	☐	☐	Alcohol Used
☐	☐	Smoked Cigarettes	☐	☐	Breathing difficulties
☐	☐	Abnormal weight gain			
☐	☐	Other (specify) _____			

BIRTH HISTORY:
Place (city or county, and state): _____ Hours of labor: _____

Was the baby on time? ☐ Yes ☐ No
If no, was he/she ☐ Early ☐ Late By how many weeks? _____

Child's Post Delivery Period:
Check which of the following problems may have occurred after the child's birth and explain the amount and treatment in the space below.

Yes	No		Yes	No	
☐	☐	Trouble Breathing	☐	☐	Jaundice
☐	☐	Cord around the neck	☐	☐	Poor Feeding
☐	☐	Required a Blood Transfusion	☐	☐	Vomiting
☐	☐	Hemorrhage (Bleeding) in Head	☐	☐	Floppy Muscle Tone
☐	☐	Hydrocephalus (water on the brain)	☐	☐	Incubator Care
☐	☐	Cyanosis (Turned Blue)	☐	☐	Infection
☐	☐	Need for ventilation	☐	☐	Fever

Number of day's infant was hospitalized after delivery: _____

INFANCY:
Were any of the following present in your baby to a significant degree during the first few years of life? If so, please describe:

Yes	No		Yes	No	
☐	☐	Did not enjoy cuddling	☐	☐	Was not calmed by being held or stroked
☐	☐	Difficult to comfort	☐	☐	Excessive restlessness
☐	☐	Excessive irritability	☐	☐	Frequent head banging
☐	☐	Difficult feeding	☐	☐	Sleeping Difficulties
☐	☐	Extremely passive			

DEVELOPMENTAL MILESTONES:
Please list the age at which your child accomplished the following developmental milestones. If you feel the milestone is not appropriate yet for the age of your child, please write N/A.

	Age:
Crawl independently	_____
Walk independently	_____
Put two words together	_____
Put 4 to 5 sentences together to relate an experience	_____
Knew primary colors	_____
Say the letters of the alphabet	_____
Print first and last name	_____
Tie shoes	_____
Snap, zip, button clothing	_____
Began to read	_____
Toilet trained	_____

HEALTH HISTORY:

When was your child's last physical exam? Date: _____ Where? _____

Vision problem? □ Yes □ No Date of vision exam: _____

Hearing problem? □ Yes □ No Date of hearing exam: _____

Please check which of the following your child has had and note the age, complications and frequency below:

Yes	No		Yes	No	
□	□	Hospitalizations	□	□	Vision Problems
□	□	Surgery	□	□	Hearing Problems
□	□	Trauma (Stitches/Broken Bones)	□	□	Asthma
□	□	Head Trauma	□	□	Allergies
□	□	Loss of Consciousness	□	□	Stomach Aches
□	□	Coma	□	□	Excessive Vomiting
□	□	Seizures	□	□	Pica (eating non-food items)
□	□	Tics	□	□	Sleep Problems
□	□	Staring Spells	□	□	Bed wetting
□	□	Tremor	□	□	Stool Soiling
□	□	Poor Muscle Tone	□	□	Bowel Problems
□	□	Falls Frequently	□	□	Ear Infections (how many?)
□	□	Anemia	□	□	Other Infections
□	□	Persistent High Fever	□	□	Accidental Poisoning
□	□	Headaches	□	□	Other Medical Problems

FAMILY HISTORY:

Child currently lives with: (Please check all that apply)

□ Natural Mother □ Natural Father □ Stepmother □ Stepfather

□ Adoptive Mother □ Adoptive Father □ Foster Mother □ Foster Father

□ Grandmother □ Grandfather □ Other (Specify) _____

If this child is adopted, please state date and age at time of adoption: _____

Mother's History:

Mother's Name: _____ Home Phone: _____
First Middle Last

Address: _____ Place of Employment: _____
(If different from child's)

Work Phone: _____ Occupation: _____

School History: Highest Grade Completed: _____ Learning Problems □ Yes □ No / Attention Problems □ Yes □ No

Does mother have any Medical Problems? □ Yes □ No
If yes, please describe: _____

_____

Are there problems similar to those of your child on the maternal side of the family?
□ Yes □ No If Yes, please describe:

_____

_____

Father's History:

Father's Name: _____ Home Phone: _____
First *Middle* *Last*

Address: _____ Place of Employment: _____
(If different from child's)

Work Phone: _____ Occupation: _____

School History: Highest Grade Completed: _____ Learning Problems □ Yes □ No / Attention Problems □ Yes □ No

Does father have any Medical Problems? □ Yes □ No
If yes, please describe: _____

_____

Are there problems similar to those of your child on the paternal side of the family?
□ Yes □ No If Yes, please describe:

_____

_____

HISTORY OF FAMILY STRESSORS OR TRANSITIONS:

Please check all that apply for the past 12 months

□ Family moved	□ Parent changed job	□ Parental separations and/or divorce	□ Conflict in family
□ Death in family / loss	□ Family financial problems	□ Family accident or illness	□ New baby at home
□ Changed school	□ Repeat a grade	□ History of abuse	□ Other (Specify)

_____

_____

EXTENDED FAMILY AND CAREGIVERS:

Names of Household Members	Age	Gender M / F	Relationship to child	Highest Grade Completed	Living in Household YES or NO
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

EDUCATIONAL HISTORY:

School Experience:
If your child does not yet attend school, write N/A on the line marked "Name of Child's School" and move down to the section marked "Home Life".

Did your child attend preschool? □ Yes □ No If yes, at what age? _____

Name of Preschool: _____

Were you concerned about your child's ability to succeed in preschool? □ Yes □ No

Name of Child's Current School: _____

School District: _____

Grade: _____ Teacher: _____

Present class placement: □ regular class □ special class (if so, specify) _____
□ ESL □ Bilingual

Has testing been completed by school? □ Yes □ No Date: _____

Is your child: □ Often □ Seldom □ Never absent from school?
Usual reason for absence: _____

Has your child ever been retained? □ Yes □ No What grade? _____ Why? _____

At what level do you feel your child is functioning compared to other children their age? _____

Has your child ever been:
□ Suspended from school Number of Suspensions _____
□ Expelled from school Number of Expulsions _____

HOME LIFE:

What are the child's favorite activities? _____

Is your child assigned regular chores to complete?_____

How often must you discipline your child & for what? _____

What forms of discipline are used? _____

Describe your child's typical mood?_____

Most of the time, are your child's interactions with other kids _____ poor, _____ fair, _____ great.
Does your child play with other kids _____ never, _____ seldom, _____ sometimes, _____ always.
Does your child get along best with _____ older, _____ same age, _____ younger children.