



# Pediatric Registration Form

<b>Personal Information</b>	Today's date: _____
Name: _____ Date of Birth: _____ Age: _____ SSN: _____	
Address: _____ City: _____ State: _____ Zip: _____ Phone: _____	
Mother's name: _____ Father's name: _____	
Address (if different from above) _____	
Legal Guardian: _____ Best Phone: _____ Alternate Phone: _____	
Address: _____	
Emergency Contact Person: _____ Relationship: _____ Phone # _____	
Referred to this office by: _____ Learned about Holistique Medical Center from: _____	

<b>Insurance Information</b>
Subscriber/Guarantor: _____ Relationship: _____ Date of Birth: _____ SSN: _____
Primary Insurance: _____ Group #: _____ Subscriber #: _____
Guarantor's address (if different than child's): _____

<b>Health Problems</b> – Please list your main health problems, duration, and current treatments
1. _____
2. _____
3. _____
4. _____

<b>Diet and Nutrition</b>
Nursed: _____ How Long: _____ Solid foods first introduced: _____
List foods excluded from diet: _____
Vegetarian? _____ For how many years? _____ Vegan? _____ % of raw food in diet: _____
Do you buy organically grown foods? _____ Drink Juice: _____ Daily Amount: _____
<b>24-hour Diet</b> – Please indicate the foods and drinks you normally take for each meal.
Breakfast
Snack
Lunch
Snack
Dinner



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**Personal History** – Check all that applies

<input type="checkbox"/> Allergies	<input type="checkbox"/> Colitis	<input type="checkbox"/> Headaches	<input type="checkbox"/> Obesity
<input type="checkbox"/> Anemia	<input type="checkbox"/> Depression	<input type="checkbox"/> Heart disorders	<input type="checkbox"/> Seizures
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Herpes genitalis	<input type="checkbox"/> Skin disorders
<input type="checkbox"/> Asthma	<input type="checkbox"/> Drug addiction	<input type="checkbox"/> Hypoglycemia	<input type="checkbox"/> Thyroid disorders
<input type="checkbox"/> Cancer	<input type="checkbox"/> Gastrointestinal disorders	<input type="checkbox"/> Liver disorders	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Cardio vascular disease		<input type="checkbox"/> Psychological disorders	<input type="checkbox"/> Venereal disease

**Other:** \_\_\_\_\_

**Medical History**

Last physical exam: \_\_\_\_\_

Previous hospitalizations/major illnesses/surgeries: \_\_\_\_\_

Known Allergies: \_\_\_\_\_ Blood Type: \_\_\_\_\_

Medication taken in the last two months: \_\_\_\_\_

Medication & Supplements: \_\_\_\_\_

Significant dental work (Type and date): \_\_\_\_\_

Significant psychological trauma: \_\_\_\_\_

Family History	Age if living	Age at death	Health concerns
Mother			
Father			
Sibling (S/B)			
Sibling (S/B)			
Sibling (S/B)			
Sibling (S/B)			

Immunizations and Dates	
MMR	
Polio	
Pertussis	
Tetanus	
Hepatitis B	

**Family Health History** - for all blood relatives, please indicate who has the following

<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Cardio vascular disease	<input type="checkbox"/> Headaches	<input type="checkbox"/> Psychological disorders
<input type="checkbox"/> Allergies	<input type="checkbox"/> Colitis	<input type="checkbox"/> Heart disorders	<input type="checkbox"/> Obesity
<input type="checkbox"/> Alzheimer's	<input type="checkbox"/> Depression	<input type="checkbox"/> Herpes genitalis	<input type="checkbox"/> Seizures
<input type="checkbox"/> Anemia	<input type="checkbox"/> Diabetes	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Skin disorders
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Drug addiction	<input type="checkbox"/> Hypoglycemia	<input type="checkbox"/> Stroke
<input type="checkbox"/> Asthma	<input type="checkbox"/> Gastrointestinal disorders	<input type="checkbox"/> Liver disorders	<input type="checkbox"/> Thyroid disorders
<input type="checkbox"/> Breast cancer		<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Cancer			<input type="checkbox"/> Venereal disease

**Other:** \_\_\_\_\_

I \_\_\_\_\_ parent/guardian hereby authorize the physicians at Holistique Medical Center to perform diagnostic tests deemed necessary for the care of my child, and to perform any and all forms of treatment, medication, and therapies indicated. Date: \_\_\_\_\_

Dr. Nooshin Darvish Dr. Elizabeth Thybulle Dr. Maydee Murdock  
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