3515 Coolidge Rd Unit A
East Lansing, MI 48823
Phone: 517-755-6888
Fax: 517-657-7759

PATIENT REGISTRATION FORM – PEDIATRIC AGE 2-12

PATIENT NAME LAST	FIRST	MIDDLE INITIAL		PATIENT DATE OF BIRTH

HOME ADDRESS	APT. NO	CITY	STATE	ZIP CODE

OCCUPATION	SOCIAL SECURITY #	MARITAL STATUS	SEX	HOME PHONE [ ] Preferred
☐ EMPLOYED ☐ RETIRED ☐ STUDENT		☐S ☐M ☐D ☐W	☐M ☐F	

EMPLOYER	E – MAIL ADDRESS	WORK PHONE [ ] Preferred
		CELL [ ] Preferred

RACE (check one)
☐ White ☐ American Indian ☐ Asian ☐ Black or African American
☐ Native Hawaiian or other Pacific Islander ☐ Other Race
☐ Decline to specify

ETHNICITY (check one) ☐ Hispanic / Latino ☐ Not Hispanic or Latino
☐ Unknown ☐ Declined to specify

PREFERRED LANGUAGE: _____

PRIMARY CARE PHYSICIAN	PRIMARY CARE PHYSICIAN PHONE	REFERRING PHYSICIAN	REFERRING PHYSICIAN PHONE

PRIMARY INSURANCE INFORMATION

SUBCRIBER'S FIRST NAME	LAST NAME	RELATIONSHIP TO PATIENT	DATE OF BIRTH

PRIMARY INSURANCE	SOCIAL SECURITY NUMBER OF SUBSCRIBER:

INSURANCE ID	GROUP / CODE	EFFECTIVE DATE	POLICY HOLDER'S BIRTH DATE

ADDRESS OF SUBSCRIBER (WRITE "SAME" IF IDENTICAL TO ABOVE)

CITY	STATE	ZIP

SECONDARY INSURANCE INFORMATION

SUBSCRIBER'S FIRST NAME	LAST NAME	RELATIONSHIP TO PATIENT	DATE OF BIRTH

SECONDARY INSURANCE	SOCIAL SECURITY NUMBER OF SUBSCRIBER:

INSURANCE ID	GROUP / CODE	EFFECTIVE DATE	POLICY HOLDER'S BIRTH DATE

ADDRESS OF SUBSCRIBER (WRITE "SAME" IF IDENTICAL TO ABOVE)

CITY	STATE	ZIP

Pharmacy Information:

Pharmacy Name: _____

Pharmacy Location/Address: _____

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Pharmacy Phone Number: _____

PEDICATRIC QUESTIONARE

Patient Name: _____ Date of Birth: _____ Date: _____
Questionnaire Filled out by: _____ _____
Name Relationship to Patient

Please state, in your own words, the reason why you, or your child's physician referred you to our clinic:

_____

At what age did this problem begin? _____ years _____ months
Has there been a change in this problem? Yes_____ No _____
If Yes, please explain how this problem has changed?

_____

CHILD'S BIRTH HISTORY

- Was this a normal delivery? Yes _____ No _____ If No, Please explain: _____
- Born earlier than due date? Yes _____ No _____ If Yes, Please explain: _____
- Was oxygen needed at birth? Yes_____ No_____ If Yes, Please explain: _____
- Extended hospital stay after birth? Yes ____ No ____ If Yes, Please explain:
  _____

CHILD'S FAMILY and SOCIAL HISTORY

- Does anyone in your child's family have a sleep problem? If Yes, please state who and type of problem:

_____

- Is your child enrolled in a special education class? Yes _____ No _____
- What are your child's average grades? _____
- How many household members are there within the home where the patient lives? _____
  - With whom does the child live with? _____
- Does anybody smoke within the home? _____
- Are there indoor pets within the home? If Yes, what type and how many? _____
- Does the child consume caffeinated beverages? Yes _____ No _____ If Yes, _____ cups daily

CHILD'S CURRENT HISTORY

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My child has the following: (Please select all which apply)

- ○ Asthma
- ○ Frequent Strep Throat
- ○ Chronic Bronchitis
- ○ BiPolar/ Depression
- ○ Delayed Growth
- ○ Learning Disability
- ○ Congestion
- ○ Frequent Colds
- ○ Heart Issues
- ○ ADD/ ADHD/ ODD
- ○ Developmental Delay
- ○ Autism
- ○ Seizures/ Epilepsy
- ○ Frequent Ear Infections
- ○ Acid Reflux
- ○ Down's Syndrome
- ○ Allergies
- ○ Other

Has the patient had any previous ears, nose or throat surgeries? Yes_____ No _____

Tonsils _____ Date of Surgery _____

Adenoids _____ Date of Surgery _____

Other _____ Date of Surgery _____

MEDICATIONS

Please indicate all current medications, prescription and over the counter, being taken currently or have taken within the last 30 days:

Medication Name	Dosage Mg	Reason

Does the patient have any medication allergies? Yes _____ No _____ If Yes, Please indicate below:

Medication Name	Medication Reaction (ie: rash, hives, swelling, redness)

ABOUT SLEEP:

During sleep, my child: (Please check **ALL** which apply)

- ○ Poor Sleeper
- ○ Has Restless Sleep
- ○ Snores
- ○ Continuously Snores
- ○ Snores Loudly
- ○ Gasps for Air
- ○ Makes Chocking Sounds
- ○ Heavy Breathing

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- Struggles Breathing
- Stops Breathing
- Looks Pale or Blue
- Sweats during Sleep
- Wets the Bed
- Rocks his/her Head
- Kicks Legs in Sleep
- Bang his/her Head
- Night Terrors
- Sleepwalking
- Sleep talking
- Nightmares
- Grinds teeth
- Gets out of Bed
- Complains of uncomfortable feeling in child's legs; creepy or crawly feeling

PATIENT'S SLEEP SCHEDULE:

	WEEKDAYS	WEEKENDS/ VACATIONS
Child's usual bedtime?	_____AM/PM	_____ AM/PM
Child's usual awake time?	_____ AM/PM	_____ AM/PM
Child's sleep duration per night?	_____ AM/PM	_____ AM/PM
How long does it take for the child to fall asleep?	_____MINUTES	
What is the number of awakenings each night?	_____TIMES	
How long is the duration of each awakening?	_____HRS/MIN	

- Does the patient take regular naps? Yes_____ No _____
  - If, Yes: How many? _____naps
  - Usual nap times: Nap 1: _____ Nap 2: _____ Nap 3: _____
- Does the child have a regular bedtime routine? Yes _____ No _____
- Does the child have their own bedroom? Yes _____ No _____
  - Do they have their own bed?
- Is a parent present when the child falls asleep? Yes _____ No _____
- Does the child resist going to bed? Yes _____ No _____
- Does the child have difficulties falling asleep? Yes _____ No _____

Please place the correct statement (by the number indicated of 1-5) which best describes:

1. Own room, own bed (alone)
2. Sibling's room, own bed
3. Parent's room, own bed
4. Sibling's room, sibling's bed
5. Parent's room, parent's bed

- _____ The child usually falls asleep where?
- _____ Where does the child usually sleep most nights?
- _____ Where does the child usually awaken in the morning?

Please indicate **ALL** statements which apply **ABOUT AWAKENING**:

- Difficult to get out of bed
- Bedsheets disorganized
- Lack of appetite

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- Morning grogginess
- Morning headaches
- Difficulty awakening

Please indicate **ALL** statements which apply **DURING THE DAY:**

- Breathe through the nose
- Problems swallowing
- Reports unable to move when falling asleep or upon awakening
- Becomes weak /lose of muscle tone when excited, angry or laughing (jaw or head dropping, knee buckling, falling on the floor, difficulty talking) for 1-2 minutes.
- Is “on the go” acts as if “driven by a motor”
- Sleepy during the day

FOR CHILDREN 5 YEARS OF AGE AND OLDER: (check all which apply)

- Complains of feeling tired
- Has trouble getting dressed
- Seems hyperactive
- Impulsive
- Behavioral problems
- Becomes easily upset
- Falls asleep in school
- Falls asleep in odd situations or places
- Does more poorly than expected
- Learning problems
- Seems very sensitive
- Seems excessively anxious
- Has difficulty making close friends
- Has problems with attention