St John Center for Wellness and Family Medicine
18303 Ten Mile Road, Roseville, Michigan 48066
Phone: 586-498-5160 Fax: 586-498-5199

Dear Patient,

Welcome to St. John Center for Wellness and Family Medicine. We are happy to assist you in promoting both you and your family's well being. We are extremely pleased with how so many of our families have been sharing the good news about our practice growth and our emphasis on personalized patient care. Our Providers and support staff are dedicated to making sure your experience in our office is one that you will feel good about for years to come.

To help us ensure that your first visit goes smoothly, please take a few minutes to fill out these registration and history forms completely. After completing the forms please return them to our office in the enclosed envelope, at least 1 week prior to your scheduled appointment date. Our caregivers feel very strongly that in order to make your appointment as rewarding as possible, they must be able to review your history **before** you arrive. This frequently takes 20-30 minutes. **Therefore, if the paperwork is not received prior to the day of your appointment, it will be cancelled.** It is of the utmost importance that you arrive 15 minutes prior to your appointment time to complete the registration process; any tardiness on your part will delay your appointment.

Lastly, please remember to bring the following with you to your appointment:

- Health history records
- Immunization records
- **ALL** current medications, vitamins and supplements – bring the bottles.
- Insurance cards
- Insurance co-pay (if there is a co-payment required by your insurance company contract each time you visit the office for any service. Payment is always expected at the time of service.)

If you have any questions concerning the forms or need to cancel or reschedule your appointment, please call (586) 498-5160.

Yours in Good Health,

St John Center for Wellness and Family Medicine Staff

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PATIENT REGISTRATION FORM

PATIENT

Name Mr. Mrs. Ms.	**Last**	**First**	**Middle**
Address			
City	**State**		**Zip Code**
Date of Birth	**Sex** M F	**Marital Status** Married Single Divorced	**Social Security Number**
Phone HOME:	**CELL:**		**WORK:**
Occupation	**Employer**		**E-MAIL**

RESPONSIBLE PARTY

Name	**Last**	**First**	**Middle**
Address			
City	**State**		**Zip Code**
Date of Birth	**Sex** M F	**Marital Status** Married Single Divorced	**Social Security Number**
Phone HOME:	**CELL:**		**WORK:**
Occupation	**Employer**		**E-MAIL**
Primary Policy Holder is:	**Patient**	**Responsible Party**	
Primary Insurance	**Plan Number**	**Group Number**	**Date of Coverage**
Secondary Policy Holder is:	**Patient**	**Responsible Party**	
Secondary Insurance	**Plan Number**	**Group Number**	**Date of Coverage**

NEAREST RELATIVE

Emergency Contact Mr. Mrs. Ms.	**Last**	**First**	**Middle**
Address			
City	**State**		**Zip Code**
Phone HOME:	**CELL:**		**WORK:**
Relationship to Patient			

How were you referred to our office? Newspaper Brochure Friend/Family Physicians Office Attended Lecture Insurance Phone Book Current Patient

- I authorize direct payment of surgical/medical benefits to St. John Center for Wellness and Family Medicine.
- Co-Payments and charges for services that are not covered by my insurance company are due at the time of the office visit. I understand that I am financially responsible for any balance not covered by my insurance.
- I authorize St. John Center for Wellness and Family Medicine to release any incidental information that may be necessary for either medical care or in the processing of applications for financial benefit.
- I certify that the information given by me in applying for payment is correct. I authorize the payment of authorized benefits on my behalf. I permit a copy of this authorization to be used in the place of the original.

SIGNATURE OF RESPONSIBLE PARTY: ______________________________ DATE: ____________

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PEDIATRIC HISTORY FORM

Instructions: Please fill out as completely as possible. All information will be kept confidential.
*BE SURE TO COMPLETE ALL **SIX** PAGES OF THIS FORM.*

PATIENT NAME: ________________________________ **DATE OF BIRTH:** ____/____/_____

MEDICATION ALLERGIES

i.e. Penicillin, Sulfa, Aspirin I.V. Dye, etc.

ALLERGIC TO: ______________________ REACTION: ______________________
ALLERGIC TO: ______________________ REACTION: ______________________
ALLERGIC TO: ______________________ REACTION: ______________________
Latex Allergy: Yes No

SURGICAL HISTORY | PHYSICIANS (SURGEONS)

Appendix Tonsils/Adenoids Ear Tubes Hernia
Other surgery ________________________________ ______________________
____ ______________________

BIRTH HISTORY

Birth History: Mom age at this child's birth?______ Vaginal Ceserean/why____________
Which pregnancy for mom for this child? ______________________
Weight at birth?________________ Weight at hospital discharge_________
Apgar score 1 minute_____________ Apgar at 5 minutes________________

Full term Early_______ weeks Late_______ weeks
Newborn complications? None, home with mother Days in hospital____
Oxygen Ventilator IV Antibiotics
Intensive Care Jaundice
Pregnancy complications? Premature labor Tobacco in pregnancy
Premature birth Alcohol in pregnancy
Gestational Diabetes Drug use in pregnancy
High blood pressure
Other______________________________________
Newborn feeding Breast/how long_________ Bottle________________

Has this child ever been hospitalized overnight? Yes No
Reason/age________________________________

How many hours of TV/Computer/Video games per day: 0-2 hours 2-4 hours > 4hours N/A
Sleep Habits: Bed time______ Wake up time_______ Sleeps all night? Yes No Naps 0 1 2 3
Sleeps where? crib toddler bed bed parent bed own room/sibling room parent room

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MEDICATIONS

Please list all medications that your child is now taking; including those that you buy without a doctor's prescriptions such as aspirin, cold tablets, vitamins and herbs. Use a separate sheet if needed.

MEDICATION	DOSE (HOW MUCH)	HOW OFTEN	MEDICATION	DOSE (HOW MUCH)	HOW OFTEN
		____Times/Day			____Times/Day
		____Times/Day			____Times/Day
		____Times/Day			____Times/Day

SOCIAL/PERSONAL HISTORY

Child currently lives:
With mother/name__________________________ Stepfather/name___________________
With father/name __________________________ Stepmother/name_________________
With relative/name/relationship)____
Foster care/name___________________________ Group home_____________________
Siblings in home/names/ages____
Siblings not in home/names/ages____
Custody arrangements (ie visits father/mother, how often?___________________________

WHO IS LEGAL GUARDIAN OF THIS CHILD? ________________________________

Current grade in school: _____ Preschool HomeSchool Special Education Speech
Current performance in school: Above Average Average Below Average
Did your child miss more than ten days of your usual activity last year due to illness? Yes No
Does anyone smoke in child's home? Yes No
Does anyone smoke in child's daycare? Yes No
Does anyone have problems with alcohol? Yes No
Does anyone use illegal drugs in child's home? Yes No
Does child exercise regularly? Yes No How often? ____ days/week
Type of exercise: _____________________
Is child secured for car ride? Rear facing car seat Forward facing car seat?
Booster seat seatbelt/rear seat with shoulder harness
Seat belt/shoulder harness front seat (over age 12-14)
Any guns in the home: Yes No If yes, are they locked up? Yes No
Is child now or ever been physically or sexually abused? Yes No
Is parent or caregiver a victim of abuse? Yes No
Does child wear helmet for biking/blading/boarding? Yes No

FEMALES ONLY
Age at first period: _____________ Last menstrual period date: _________________
Periods occur every ______days Number of days flowing _________________
Flow is regular irregular
Problems with periods? Cramps PMS
Other/describe __________________________

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REVIEW OF MEDICAL SYSTEMS

Point Scale	
	0 Child never or *almost never* has the symptom
	1 Child o*ccasionally* has it, effect is *not severe*
	2 Child o*ccasionally* has it, effect is *severe*
	3 Child f*requently* has it, effect is *not severe*
	4 Child f*requently* has it, effect is *severe*
	Depending on child age, some may not apply

HEAD
______Headaches
______Faintness/dizziness
______Difficulty going to sleep
______Frequent waking
______TOTAL

EYES
______Watery or itchy eyes
______Swollen, reddened or sticky eyelids
______Bags or dark circles under eyes
______Blurred or tunnel vision
(Does not include near- or far-sightedness)
______TOTAL

EARS
_____Itchy ears
_____Earaches, ear infections
_____Drainage from ear
_____Ringing in ears, hearing loss
_____TOTAL

NOSE
_____Stuffy nose
_____Sinus Problems
_____Hay fever
_____Sneezing attacks
_____Excessive mucus formation
_____TOTAL

MOUTH/ THROAT
_____Chronic coughing
_____Gagging, frequent need to clear throat
_____Sore throat, hoarseness, loss of voice
_____Swollen or discolored tongue, gums Or lips
_____Canker sores
_____TOTAL

SKIN
_____Acne
_____Hives, rashes, dry skin
_____Hair loss
_____Flushing, hot flashes
_____Excessive sweating
_____TOTAL

HEART
_____Irregular or skipped heartbeat
_____Rapid or pounding heartbeat
_____Chest pain
_____TOTAL

LUNGS
_____Chest congestion/cough
_____Asthma, bronchitis
_____Shortness of breath
_____Difficulty breathing
_____TOTAL

DIGESTIVE TRACT
______Nausea, vomiting
______Diarrhea
______Constipation
______Usual number of bowel movements
______Heartburn/abdominal pain
______ Frequent/excessive spitting up (baby)
______TOTAL

JOINTS/ MUSCLE
______Pain or aches in joints
______Arthritis
______Stiffness or limitation of movement
______Pain or aches in muscles
______Delayed development i.e.: late walking
______TOTAL

WEIGHT
_____Binge eating/drinking
_____Craving certain foods/picky eater
_____Excessive weight
_____Compulsive eating
_____lack of appetite
_____Underweight
_____TOTAL

ENERGY/ ACTIVITY
_____Fatigue, sluggishness
_____Apathy, lethargy
_____Hyperactivity
_____Restlessness
_____TOTAL

MIND
_____Poor concentration
_____Confusion, poor comprehension
_____Sadness/low self esteem
_____overly active
_____Stuttering or stammering
_____Speech/pronunciation problem
_____Learning Disabilities
_____TOTAL

EMOTIONS
_____Mood swings/excessive fussiness
_____Anxiety, fear, nervousness
_____Anger, irritability, aggressiveness
_____Depression
_____TOTAL

OTHER
_____Frequent illness
_____Frequent or urgent urination
_____Usual number of urination/day
_____Genital itch or discharge
_____TOTAL

GRAND TOTAL ______________________

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CHRONIC MEDICAL PROBLEMS

Please check ALL conditions that apply to your child:

☐Feeding problems 783.3
☐Failure to thrive 783.41
☐Slow weight gain/underweight 783.22
☐Recent weight loss 783.21
☐Rapid weight gain 783.1
☐Overweight 278.00
☐Loss of appetite, recent 783.0
☐Constipation, chronic 564.00
☐Constipation, current 564.00
☐Diarrhea, chronic 006.1
☐Diarrhea, current 787.91

☐Encopresis (leaking stool) 307.7
☐Bedwetting (over age 4) 788.36
☐ Frequent Urinary Infections 599.0

☐Behavior problems V71.02
☐Discipline problems V71.02
☐Developmental delay –describe____________________
☐Sleep problem 780.52
  ☐Night terrors 307.46
  ☐Nightmares 307.47
  ☐Sleepwalking 307.46
☐ Sleep Apnea 780.57

☐ High Blood Pressure 401.1
☐ Diabetes Type I 250.01
☐ Diabetes Type II 250.00
☐ Metabolic Syndrome / Insulin Resistance 277.7
☐ Elevated Cholesterol 272.4
☐ Elevated Triglycerides ONLY 272.1
☐ Elevated thyroid hormone 242.90
☐ Low thyroid hormone 244.9
☐ Pre-Menstrual Syndrome (PMS) 625.4

☐Frequent Ear infections (> __/year) 380.10
☐ Hearing Loss 389.9
☐Speech problems 784.5
☐Vision problems 368.31

☐ Asthma 493.90
☐ Allergies – seasonal 477.9
☐ Allergies – cats, dogs 477.2

☐ Congenital heart disease 746.9
☐ Heart Murmur 785.2

☐Abdominal pain, chronic or recurrent 789.00
☐ Irritable Bowel Syndrome(IBS) 564.1
☐ Esophageal Reflux 530.81
☐ Ulcerative Colitis 556.9
☐ Hepatitis 571.4

WELL CHILD – No Medical problems V20.2

☐ Migraine Headaches 346.9
☐ Seizure Disorder 780.39

☐ Anxiety 300.00
☐ Depression 311
☐ Manic Depression(Bipolar) 296.8
☐ Obsessive Compulsive Disorder(OCD) 300.3
☐ Attention Deficit with hyperactivity(ADHD) 314.01
☐ Attention Deficit without hyperactivity(ADD) 314.00
☐ Oppositional Defiant disorder
☐ Anorexia 783.0
☐ Bulimia 783.6

☐ Acne 706.1
☐ Eczema 691.8
☐ Rheumatoid Arthritis 714.0

☐ Anemia -iron deficiency 280.9
☐ Anemia – any other type 285.9

CANCER of the:
☐ Brain 191.9
☐ Kidney 189.0
☐ Skin 173.9
☐ Leukemia 204.00
☐ Neurofibromatosis 237.70
☐Other________________________

Please specify any other chronic medical problems:

____
____
____
____
____
____
____
____
____

THE ST. JOHN CENTER FOR WELLNESS AND FAMILY MEDICINE

PEDIATRIC FAMILY HISTORY

For each member of your family, follow the gray or white line across the page and check the boxes for their present state of health, and any illnesses they have had.

Note: Family refers to blood or natural relatives. PRINT NAMES AND AGES BEL0W	Good Health	Poor Health	Deceased	Write in the age and cause of death. Include accidents and suicides.	**Alcoholism**	**Allergies or Asthma**	**Alzheimer's or Dementia**	**Anemia**	**Blood Clotting Problems**	**Diabetes**	**Cancer or Tumor**	**Epilepsy**	**Genetic Disease**	**Heart Trouble**	**High Blood Pressure**	**High Cholesterol**	**Kidney or Bladder Disease**	**Depression or Anxiety**	**Rheumatism or Arthritis**	**Stomach or Duodenal Ulcer**
Father:																				
Mother:																				
Brothers/Sisters:																				
Grandmother (Mother side)																				
Grandfather (Mother side)																				
Grandmother (father side)																				
Grandfather (father side)																				

What are your main concerns about your child today?

____

____

____

____

____

____

Do you have any concerns about your child's development, behavior, school performance, or other issues?

____

____

____

____

____

____

____

____

____

____

Parent/Guardian Signature

____

Date _____/_____/_______

Reviewed by ____________________________Pazuchowski/Whitmyer/Collinson