Pediatric New Patient History and Demographics

Please fill out all information to the best of your ability.

Patient Demographics:

Date: ____/____/____

Last Name:	First Name:	Preferred Name:	
Parent Name:			
Date of Birth: __/__/__	Age:	Handedness: Right Left Both	
Street Address:			
City:	State:	Zip Code:	County:
Is this a residential facility? Yes No	Name of Facility and Contact:		
Home Phone:	Cell Phone:	Work Phone:	
Preferred Contact Method: (Circle):	Home	Cell	Work

Patient's Race:

American Indian		Alaskan Native		African American/Black	
Native Hawaiian		Pacific islander		Asian	
Hispanic		White Caucasian		Other/Prefer not to Identify	

Country of Origin: ____________________ Languages Spoken: ____

Legal Custody:

Parent ☐ Self ☐ Other ☐ *(If other, please list under guardianship information)*

Guardianship Information:

Last Name:	First Name:		
Street Address:			
City:	State:	Zip Code:	County:
Home Phone:	Cell Phone:	Work Phone:	
Preferred Contact Method: (Circle):	Home	Cell	Work

Emergency Contact:

Last Name:	First Name:		
Street Address:			
City:	State:	Zip Code:	County:
Home Phone:	Cell Phone:	Work Phone:	

Family Medical History:

Relation:	Age:	Seizure/Epilepsy History?	Other Health Issues:	Deceased?	Cause of Death:
Mother:					
Father:					
Sisters					
Brothers:					
Maternal Grandfather:					
Maternal Grandmother:					
Paternal Grandfather:					
Paternal Grandmother:					
Additional:					