NOGGIN

GENERAL CLIENT INFORMATION

Name (Last, First):

Phone (Primary):

Phone 2 (Secondary):

Primary Address:

Secondary Address (Optional):

Email Address:

Date of Birth:

Occupation:

Spouse Name (Last, First):

Spouse Phone (N/A if same as primary):

Spouse Email:

Spouse Primary Address (N/A if same as primary):

CHILD INFORMATION

Name (Last, First):

Date of Birth:

Sex:

Primary Guardian:

Teacher/Daycare Provider Phone/Email (List all):

If your child is enrolled in a day-care, in-home care or group-care setting, please provide the following: Address of Facility and Enrollment Schedule

If your child is nannied, please provide the following: Hours child is nannied weekly, child's current relationship to nanny, nanny's credentials/qualifications (attach resumé if available):

CHILD GENERAL HEALTH INFORMATION*

Pediatrician/PHP Phone/Email:

Primary Child Dentist Phone/Email:

Licensed Child Speech Pathologist/OT/Chiropractor/Other Therapist Phone/Email (List all below):

ALLERGIES (Allergen, Date Last Tested, Medications Administered for allergy-related symptoms):

Diagnosed Medical Condition(s) (Please list all):

Date of Last Appointment*:

Reason for Last Appointment*:

Prescribed Medications (Please list all):

Over-the-Counter Medications (Type, Usage, Dosage):

☐Child has frequent colds, ear infections, colic, etc. - Describe:

UPDATES (For Office Use Only):

MEALS

Current Feeding Schedule

Food Type:

☐Formula ☐Strained ☐Junior ☐Table ☐Milk Type - Specify:

New Food Timetable:

When eating, child is -

☐Held in lap ☐In highchair ☐Other-Specify:

Feeds Self:

☐Yes ☐No If “Yes”, uses: ☐Spoon ☐Fork ☐Hands

Feeding Problems (Please address any and all concerns with your child’s feeding habits):

Favorite Foods- Specify:

Refused Foods - Specify:

UPDATES (For Office Use Only):

SLEEP

Current Sleep Schedule (Weekdays & Weekends):

Falls asleep easily ☐Yes ☐No

Takes favorite toy(s) to bed - **child over age 1 year**

☐Yes ☐No If “Yes” - list toy(s):

Sleep Position - **child under age 1 year**

☐Back ☐Side or stomach

UPDATES (For Office Use Only):

VERBAL COMMUNICATION

Family speaks what language -

☐English ☐Other ☐If “Other” - Specify:

Age child began talking

Child speaks in

☐Words ☐Sentences

Words used to describe special needs - Specify (buh-buh, binkie, etc.)

UPDATES (For Office Use Only):

COMFORTING

Does the child have a fussy time?

☐Yes ☐No If “Yes” - Specify time.

How is fussy time handled? (Be specific)

Child likes to be:

☐Held ☐Sung to ☐Rocked ☐Other - Specify:

Special things you say or do to comfort the child:

UPDATES (For Office Use Only):

SELF-EXPRESSION

What causes your child to feel angry or frustrated?

What frightens your child and how is it shown?

How does your child express feelings of happiness, enjoyment, etc.?

Additional comments

UPDATES (For Office Use Only):

PHYSICAL AND SOCIAL DEVELOPMENT

Is your child able to - (Check all that apply)

☐Sit up alone ☐Pull up ☐Crawl ☐Walking holding on to support surface

Is your child used to playmates?

☐Yes ☐No

Comments:

UPDATES (For Office Use Only):

By providing complete and thorough information about your child, you will be assisting me in providing the highest quality care possible for your child.

_____ _____

SIGNATURE - Parent or Guardian Date Signed

_____

SIGNATURE - Parent or Guardian