PATIENT REGISTRATION FORM

Amy Joy Smith, NP

Phone: 714-782-0042

Please call our office as soon as possible to cancel or change your appointment.

Our email address is admin@amyjoysmith.com.

Please complete the following:

Name

First Name Last Name

Date of Birth: *

Month Day Year

Date

Month Day Year

Address

Street

City State Zip

Home Phone:

Cell:

Work:

Email: *

example@example.com

Age:

Gender: *

Occupation:

If minor: I live with:

- [ ] Parents
- [ ] Siblings
- [ ] Extended Family
- [ ] Other

Parent Information

	Parents Name	Cell Phone	Home Phone	Marital Status
#1				
#2				

Who should be contacted regarding appointments and other matters

- [ ] Self
- [ ] Other

Pharmacy name, address and phone number

Local PCP, provider. Name, address, phone number

INSURANCE

Insurance Company

Policyholder's name, date of birth, and relationship to you;

Member ID number;

Rx BIN, PCN, and Group ID or Rx Group if applicable)

IN CASE OF EMERGENCY

Emergency Contact Person:

Phone Number:

How did you hear about Amy Smith?

Reason for visit:

PATIENT MEDICAL DATA

Please list all allergies and sensitivities. (drugs, foods, chemicals, environmental):

Please list all current medications (include over-the-counter and prescription medications): If none please put none in first box

	Medication	Dose	Frequency Taken
Medication Name/ Dose/ Frequency			
Medication Name/ Dose/ Frequency			
Medication Name/ Dose/ Frequency			
Medication Name/ Dose/ Frequency			
Medication Name/ Dose/ Frequency			
Medication Name/ Dose/ Frequency			

Supplement list (Please list all herbs, vitamins, nutritional supplements, with dosage if possible):

Please list all medical diagnoses:

Please list all surgeries (with year):

Please list all hospitalizations (with year)

Please list all therapies you use acupuncture, massage, physical therapy etc:

HEALTH HISTORY

Please list your health problems in order of importance to you

1. *

2.

3.

4.

5.

6.

7.

8.

9.

10.

Please list all animals you come in contact with

FAMILY HISTORY

	Mother	Father	Sisters	Brothers	Children
Age(if living)					
Health (Good, Fair, poor)					
Age of Death (if deceased)					

LIFESTYLE AND HABITS

Check all the apply:

	Mother	Father	Sisters	Brothers	Children
Asthma	☐	☐	☐	☐	☐
Allergies / Mast cell	☐	☐	☐	☐	☐
Autoimmune	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐
Cardiovascular/ BP	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐
Epilepsy/ Seizures	☐	☐	☐	☐	☐
Food intolerance	☐	☐	☐	☐	☐

	Mother	Father	Sisters	Brother	Children
Heart disease	☐	☐	☐	☐	☐
Immune / infections	☐	☐	☐	☐	☐
Kidney disease	☐	☐	☐	☐	☐
Mental Health Issues	☐	☐	☐	☐	☐
Thyroid disease	☐	☐	☐	☐	☐
OTHER	☐	☐	☐	☐	☐

DESCRIBE A TYPICAL MEAL:

Breakfast

Lunch

Dinner

Snacks

Drinks

What are your three favorite foods?

1st

2nd

3rd

What three foods do you dislike the most?

1st

2nd

3rd

Do you:

	Yes	No	If applicable Please Describe
Average 6-8 hours' sleep?	☐	☐	
Have a supportive relationship?	☐	☐	
Have a history of trauma?	☐	☐	
Have a history of abuse?	☐	☐	
Take vacations?	☐	☐	
Spend time outside?	☐	☐	
Watch television? How many hours weekly?	☐	☐	
Read books? How many hours weekly?	☐	☐	
Computer games/browsing? How many hours weekly?	☐	☐	
Spiritual/Religious practice? Please describe	☐	☐	
Do you smoke? How much?	☐	☐	
Did you smoke in the past? How many years? How many packs a day?	☐	☐	

Do you eat three meals a day?	☐	☐	
Do you eat out often? **How many meals per week?**	☐	☐	
Do you drink coffee? **How many cups a day?**	☐	☐	
Do you drink tea? **How many cups a day?**	☐	☐	
Do you drink soft drink? **How many cups a day?**	☐	☐	
Do you use sugar? **How much?**	☐	☐	
Use alcoholic beverages? **How often?**	☐	☐	
Enjoy your work	☐	☐	

Yes= A problem you have now
No=Never had this problem
Past= Had it in the past

Mental/Emotional

	Y	N	P
Mood Swings	☐	☐	☐
Depression	☐	☐	☐
Anxiety/Nervousness	☐	☐	☐
High Stress Level	☐	☐	☐
Memory Problems	☐	☐	☐
Considered Suicide	☐	☐	☐
Poor Concentration	☐	☐	☐

REVIEW OF SYSTEMS

Gastrointestinal

	Yes	No	Past	Remarks
Bowel Movements- How Often?	☐	☐	☐	
Nausea	☐	☐	☐	
Vomiting	☐	☐	☐	
Vomiting Blood	☐	☐	☐	
Trouble Swallowing	☐	☐	☐	
Blood in Stool	☐	☐	☐	
Pain/Cramps/Bloating	☐	☐	☐	
Belching or Gas	☐	☐	☐	
Gall Bladder Disease	☐	☐	☐	
Liver Disease	☐	☐	☐	
Heartburn	☐	☐	☐	
Change in Appetite	☐	☐	☐	
Constipation	☐	☐	☐	
Diarrhea	☐	☐	☐	
Black Stools	☐	☐	☐	
Ulcers	☐	☐	☐	
Hemorrhoids	☐	☐	☐	

Cardiovascular

	Yes	No	Past
Heart Disease	☐	☐	☐
High Blood Pressure	☐	☐	☐
Low Blood Pressure	☐	☐	☐
Blood Clots	☐	☐	☐
Phlebitis	☐	☐	☐
Rheumatic Fever	☐	☐	☐
Swelling in Ankles	☐	☐	☐
Angina	☐	☐	☐
Heart Murmurs	☐	☐	☐
Fainting	☐	☐	☐
Irregular Heartbeat	☐	☐	☐
Chest Pain	☐	☐	☐

Urinary

	Yes	No	Past	Remarks
Pain on Urination/ Frequency	☐	☐	☐	
Frequent Infections	☐	☐	☐	
Inability to Hold Urine	☐	☐	☐	
Frequency at Night?	☐	☐	☐	
Kidney Stones	☐	☐	☐	

Male Reproductive

	Yes	No	Past	Remarks
Testicular Pain	☐	☐	☐	
Sexually Active	☐	☐	☐	
Premature Ejaculation	☐	☐	☐	
Impotence	☐	☐	☐	
Prostrate Disease	☐	☐	☐	
Hernias	☐	☐	☐	
Testicular Masses	☐	☐	☐	
Sexually Transmitted Disease If so, what kind	☐	☐	☐	

Female Reproduction

	Yes	No	Past	Remarks
Age of first period	☐	☐	☐	
Date of last period	☐	☐	☐	
If menopausal, date of last period	☐	☐	☐	
Length of cycles	☐	☐	☐	
Are they regular?	☐	☐	☐	
Bleeding between cycles	☐	☐	☐	
Clotting/Heavy Bleeding	☐	☐	☐	
Discharge	☐	☐	☐	
Menopause Symptoms	☐	☐	☐	
Painful Periods?	☐	☐	☐	
Endometriosis?	☐	☐	☐	
Ovarion Cysts?	☐	☐	☐	
Sexually Active?	☐	☐	☐	
Dizziness?	☐	☐	☐	
Birth Control? If so, what kind	☐	☐	☐	

STD? If so, what kind	☐	☐	☐	
Breast Pain?	☐	☐	☐	
Breast Lumps?	☐	☐	☐	
Nipple Discharge?	☐	☐	☐	
PMS, what symtoms?	☐	☐	☐	
Number of pregnancies	☐	☐	☐	
Number of live births	☐	☐	☐	
Number of abortions	☐	☐	☐	
Abnormal pap	☐	☐	☐	

General

	Remarks
How much do you weigh?	
Are you happy with your weight	
Height	

Neurologic

	Y	**N**	**P**
Muscle Weakness	☐	☐	☐
Loss of Memory	☐	☐	☐
Dizziness Memor	☐	☐	☐
Paralysis	☐	☐	☐
Numbness	☐	☐	☐
Tingling	☐	☐	☐
Seizures	☐	☐	☐

Nose and Sinus

	Y	**N**	**P**
Stuffiness	☐	☐	☐
Sinus Pain	☐	☐	☐

Nose Bleeds	☐	☐	☐
Hay Fever	☐	☐	☐
Frequent Colds	☐	☐	☐

Musculoskeletal

	Y	N	P
Joint Pain	☐	☐	☐
Joint Stiffness	☐	☐	☐
Back Pain	☐	☐	☐
Neck Pain	☐	☐	☐
Weakness	☐	☐	☐
Broken Bones	☐	☐	☐
Arthritis	☐	☐	☐
Sciatica	☐	☐	☐
Muscle Spasm	☐	☐	☐

Skin

	Y	N	P
Rashes	☐	☐	☐
Acne	☐	☐	☐
Boils	☐	☐	☐
Lumps	☐	☐	☐
Eczema	☐	☐	☐
Hives	☐	☐	☐
Hair Loss	☐	☐	☐
Night Sweats	☐	☐	☐

Mouth and Throat

	Y	N	P
Sore Throats	☐	☐	☐
Teeth Grinding	☐	☐	☐

Gum Problems	☐	☐	☐
Dental Cavities	☐	☐	☐
Jaw Clicks	☐	☐	☐
Hoarseness	☐	☐	☐

Neck

	Y	N	P
Lumps	☐	☐	☐
Goiter	☐	☐	☐
Swollen Glands	☐	☐	☐
Pain/Stiffness	☐	☐	☐

Endocrine

	Y	N	P
Hypothyroidism	☐	☐	☐
Hypoglycemia	☐	☐	☐
Excessive Thirst	☐	☐	☐
Fatigue	☐	☐	☐
Feel too Hot	☐	☐	☐
Feel too Cold	☐	☐	☐
Excessive Hunger	☐	☐	☐
Seasonal Depression	☐	☐	☐

Immune

	Y	N	P
Chronic Infections	☐	☐	☐
Chronic Fatigue	☐	☐	☐
Frequent Infections	☐	☐	☐
Slow Wound Healing	☐	☐	☐
Has your child had COVID? (dates)	☐	☐	
Has anyone in your (home) family had COVID? (dates)	☐	☐	

Head

	Y	N	P
Migraines	☐	☐	☐
Head Injury	☐	☐	☐
Jaw/TMJ Pain	☐	☐	☐
Headaches	☐	☐	☐

Respiratory

	Y	N	P
Cough	☐	☐	☐
Spitting up blood	☐	☐	☐
Asthma	☐	☐	☐
Pneumonia	☐	☐	☐
Pain on Breathing	☐	☐	☐
Tuberculosis	☐	☐	☐
Difficulty Breathing	☐	☐	☐
Bronchitis	☐	☐	☐

Eyes

	Y	N	P
Impaired Vision	☐	☐	☐
Spots in Vision	☐	☐	☐
Cataracts	☐	☐	☐
Glasses or Contacts	☐	☐	☐
Eye Pain	☐	☐	☐
Dryness	☐	☐	☐
Glaucoma	☐	☐	☐

Ears

	Y	N	P
Impaired Hearing	☐	☐	☐
Earaches	☐	☐	☐
Ringing	☐	☐	☐

Dizziness	☐	☐	☐

Blood Vessels

	Y	N	P
Easy Bleeding/Bruising	☐	☐	☐
Deep Leg Pain	☐	☐	☐
Varicose Veins	☐	☐	☐
Anemia	☐	☐	☐
Cold Hands/Feet	☐	☐	☐
Thrombophlebitis	☐	☐	☐

Immunizations

- ☐ Polio
- ☐ Measles/Mumps/Rubella Diphtheria
- ☐ Meningitis
- ☐ Tetanus
- ☐ Pertussis
- ☐ Has your child has the COVID vaccine?
- ☐ If yes, which vaccine and when? _____
- ☐ Other _____

Childhood Illnesses

- ☐ Mumps
- ☐ Measles
- ☐ Diptheria
- ☐ Chicken Pox
- ☐ German Measles
- ☐ Rheumatic Fever

X Rays and Special Studies

List Scans and x-rays you have had. Include Cat Scan, MRI Scan, Xrays, Heart studies other special studies.

PANDAS/PANS Supplemental Questionnaire

When exactly did your child's symptoms begin?

Please describe your child's symptoms at onset of PANDAS/PANS?

Has family has been tested for strep? If so, when?

Do you or your spouse have a family history that includes frequent strep illness, rheumatic illness, scarlet fever or related infections, autoimmune illness or gluten-related issues?

On a scale of 1-10 please rate your child's current level of overall symptom severity

Has your child been diagnosed with PANDAS/PANS?

If so, when and by whom?

Do you have any other children with PANDAS/PANS or another neuropsychiatric, behavioral or developmental disorder?

Has your child ever been tested for the following? If yes, please indicate when and outcome of test. If your child was tested for Lyme related infections, please indicate which lab ran the test.

	Lab	Date	Results
Strep			
Lyme			
Lyme co-infections			
Mycoplasma pneumonia			
Immune deficiency			
PANDAS (Cunningham Panel)			
Food Allergies			
Viral Illness			
Autoimmune disease			
Functional Stool Testing or other GI Workup			

Do you need help communicating to your child's school?

Please list all of your child's medical diagnoses and dates of onset

	Diagnosis	Date	Provider
1			
2			

3			
4			
5			
6			
7			
8			
9			
10			

In addition to medical care for your child and a magic wand, what else do you need for their care or your family's care at this time?

How many additional/other providers have you consulted with since the onset of your child's symptoms and in which specialty?

		Specialty	Approx dates when started	Remarks
Provider Name				
Provider Name				
Provider Name				
Provider Name				
Provider Name				
Provider Name				

Which provider(s) have helped your child the most? Name / Specialty

Is your child in school?

- ☐ Yes- Do you have a special school accommodation (IHP, IEP or 504 plan) ? Please explain below
- ☐ No- Please explain below
- ☐ Other

PANS 31-Item Symptom Rating Scale (PANS Rating Scale)

Name/Participant ID:_____ Date:_____ Completed by: ☐ Mother ☐ Father ☐ Other_____

Please rate the following symptoms based on their severity during the past week. **Severity Ratings:** 0 – None 1 – Mild: Slight interference in family, school, or social situations. Overall, symptoms are not impairing. 2 – Moderate: Definite interference in family, school, or social situations, but still manageable. 3 – Severe: Causes substantial interference in family, school, or social situations. 4 – Extreme: Incapacitating symptoms.	*Please check box 0-4 to best represent severity*				
	None	**Mild**	**Moderate**	**Severe**	**Extreme**
Symptom Type: (*See definitions on next page)	**0**	**1**	**2**	**3**	**4**
1. Obsessions*	☐	☐	☐	☐	☐
2. Compulsions*	☐	☐	☐	☐	☐
3. Hoarding	☐	☐	☐	☐	☐
4. Food refusal/avoidance	☐	☐	☐	☐	☐
5. Urge to overeat; thinking about eating all the time	☐	☐	☐	☐	☐
6. Fluid refusal/avoidance	☐	☐	☐	☐	☐
7. Separation anxiety	☐	☐	☐	☐	☐
8. Other anxiety/fears/phobias/panic attacks	☐	☐	☐	☐	☐
9. Mood swings*/moodiness	☐	☐	☐	☐	☐
10. Emotional lability (inappropriate crying or laughing spells)	☐	☐	☐	☐	☐
11. Suicidal ideation/behavior*	☐	☐	☐	☐	☐
12. Depression/sadness	☐	☐	☐	☐	☐
13. Irritability*	☐	☐	☐	☐	☐
14. Oppositional behaviors	☐	☐	☐	☐	☐
15. Aggressive behaviors* and/or rage	☐	☐	☐	☐	☐
16. Hyperactivity or impulsivity	☐	☐	☐	☐	☐
17. Trouble paying attention	☐	☐	☐	☐	☐
18. Baby talk	☐	☐	☐	☐	☐
19. Other behavioral/developmental regression (poor self-care, immature judgment for age)	☐	☐	☐	☐	☐
20. Worsening of school performance	☐	☐	☐	☐	☐
21. Worsening of handwriting/copying/artwork	☐	☐	☐	☐	☐
22. Cognitive symptoms (difficulty thinking, foggy brain, memory problems)	☐	☐	☐	☐	☐
23. Pain (headaches, abdominal pain, body pain)	☐	☐	☐	☐	☐
24. Sleep disturbance	☐	☐	☐	☐	☐
25. Daytime wetting or bedwetting (enuresis)	☐	☐	☐	☐	☐
26. Urinary frequency (uses restroom frequently)	☐	☐	☐	☐	☐
27. Bothered by sounds, smells, textures, or lights (sensory amplification)	☐	☐	☐	☐	☐
28. Hallucinations*	☐	☐	☐	☐	☐
29. Delusions or paranoid thoughts	☐	☐	☐	☐	☐
30. Tics (movements)*	☐	☐	☐	☐	☐
31. Tics (sounds)*	☐	☐	☐	☐	☐

# of hours/day involved in obsessions:_____ # hours/day involved in compulsions/rituals:_____

PANS 31-Item Symptom Rating Scale (PANS Rating Scale)

Definitions:

Obsessions: are unwanted thoughts or images that come in to your child's head. They can be scary or embarrassing or strange. Some children have thoughts of bad things happening to their parents, or of getting sick. Some children have trouble getting the thoughts out of their head.

Compulsions: are routines, rituals, or actions that your child might feel like they need to do in order to stop bad things from happening or until something is 'just so'. Some children line things up or arrange things in a certain way, or ask their parents for reassurance.

Mood swings: are when your child's mood changes quickly and frequently. Your child may go from being happy or calm to being upset about something.

Suicidal ideation/behavior: is when your child thinks or expresses not wanting to be alive anymore, or does something intentionally to hurt themselves. An example of suicidal ideation is when a child says that they want to die or would rather be dead.

Irritability: is when your child is easily annoyed or bothered by little things that would not normally upset someone.

Aggressive behaviors: can cause physical or emotional harm to others. Examples of aggressive behavior include yelling, hitting/kicking, getting into fights, and bullying others.

Hallucinations: are when your child hears or sees things that are not there in a way that seems strange. Some children hear voices or they see people or things when no one is there.

Tics (movements) or Motor tics: are sudden jerks or movements, such as forceful eye blinking or a rapid head jerk to one side or the other. Some tics might be more subtle, like scrunching the nose. They occur during otherwise normal behavior. Other examples of motor tics include jerking the head or arms or legs, or stretching the mouth or jaw in a way that seems odd or too frequent.

Tics (sounds) or Vocal tics: are sudden utterances of sounds such as throat clearing, sniffing, or words. They can be very loud or soft. Other examples of vocal tics are repeated words or noises, or coughing.