Elevation Health Pediatric Patient Application

WELCOME TO OUR OFFICE. WE THANK YOU FOR YOUR TRUST!

Section 1: Patient Information

Appt. Date: ________________

Childs Name (first, middle, last):____

☐ Male ☐ Female Date of Birth:___/___/___ Age: _____

Address: ______________________________ Province: ______________ Postal Code: __________

Home Phone: (____)____________Cell Phone: (_____) ______________ Work Phone: (____) ________________

Mothers Name:____________________Date of Birth:_/__/___ Fathers

Name:__________________________Date of Birth:_/__/___

Section 2: Child Current Problem:

Purpose of this visit:____Wellness Check-up____Injury or Accident_____Other Please explain: ________________

If your child is experiencing ***Pain/Discomfort please identify where and for how long*** ____________________________

____

1. When did the Problem first begin? Date____/___/_____ _____Unknown______Gradual _____Sudden
2. Ever had this problem before?____No____Yes If yes when? ______________________________
3. Any bowel or bladder problems since this problem began? If yes, *(Describe)*:________________________
4. Have you seen any other doctors for this problem? No Yes If yes who? ________________________
5. How long ago?________Days ________ Weeks ________Months ________Years
6. What were the results of past treatment? ______________________________________
7. How is this problem NOW: ☐ Rapidly Improving ☐ Improving Slowly ☐ About the Same ☐ Gradually Worsening ☐ On & Off
8. Please list any medication taken for this problem: ____________________________________
9. Has your child ever sustained an injury playing organized sports? _______ If yes; please explain

   ____
10. Has your child ever sustained an injury in an auto accident?_______if yes, please explain

    ____

Guardian's Signature:____________________________________Date:_____/_____/_________

Doctor's Signature ______________________________ Date Form Reviewed:_____/_____/_________

Revised 013113

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Section 3: Check any of the following conditions your child has suffered from during the past 6 months:

☐ Headaches	☐ Digestive Disorders	☐ Behavioral Problems	☐ Dizziness	☐ Neck Problems
☐ Ear Infections	☐ Poor Appetite	☐ Stomach Aches	☐ Arm Problems	☐ Reflux
☐ Fainting	☐ Muscle Pain	☐ Leg Problems	☐ Heart Trouble	☐ Constipation
☐ Diarrhea	☐ Backaches	☐ Hypertension	☐ Asthma	☐ Anemia
☐ Scoliosis	☐ Bed Wetting	☐ Walking Trouble	☐ Poor Posture	☐ Fall from crib
☐ Allergies	☐ Chronic Colds	☐ Temper Tantrums	☐ Sleeping Problems	☐ Colic
☐ Fall off slide	☐ Fall from high chair	☐ Fall from bed or couch	☐ Fall down stairs	☐ Fall in walker
☐ Fall from changing table		☐ Fall off monkey bars	☐ Fall off skateboard/skates	

Notes ____

Section 4: Prenatal History

Name of Obstetrician / Midwife: ____________________

Complications during pregnancy ?_____N_____Y, List: ____________________

Ultrasounds during pregnancy ?_______N_____Y, Number: ____________________

Medications during pregnancy/delivery?______N_____Y, List: ____________________

Cigarette / Alcohol use during pregnancy:_____N_____Y

Birth Weight:________________Birth Length:________________

Location of Birth:______Hospital______Birthing Center_______Home

Birth Intervention:_____Forceps__________Vacuum Extraction________Caesarian Section, Emergency or Planned?

Complications during Delivery ?_______N_____Y, List: ____________________

Genetic Disorders or Disabilities:_______N_____Y, List: ____________________

Section 4: Infancy

Name of Pediatrician: ____________________

Date of Last Visit:_____/_____/_____ Reason: ____________________

Number of Doses of Antibiotics your Child has Taken:
During the past six months:________, Total During His/Her Lifetime:________

Number of Doses of Other Prescription Medications your Child has Taken:
During the past six months:________, Total During His/Her Lifetime:_________List: ____________________

Vaccination History: ____________________

Feeding History:
Breast Fed: _______N_____Y , How Long: ______

____________________ Formula Fed: ____________________N_____Y ,

How Long:___________Type: _______________ Introduced to Solids at:____________________

_____________Months , Cows' Milk at_Months

Food/Juice Allergies or Intolerances:_____N_____Y , List: ____________________

I herby authorize Elevation Health and its Doctors to administer care to my Son/Daughter as they deem necessary. I clearly understand and agree that I am personally responsible for payment of all fees charged by this office.

Guardian's Signature:________________________________Date:_____/_____/_________

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Doctor’s Signature ____ Date Form Reviewed:_____/_____/_________

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