



Elevation Health Pediatric Patient Application

PLEASE NOTE:

This file must be saved to your desktop before and after completing!

Section 1: Patient Information

Appt. Date: _____

Childs Name (first, middle, last): _____

Male Female Date of Birth: ___/___/___ Age: _____ Social Security Number: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (____) _____ Cell Phone: (____) _____ Work Phone: (____) _____

Mothers Name: _____ Social Security Number: _____ Date of Birth: ___/___/___

Fathers Name: _____ Social Security Number: _____ 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: ___/___/____

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

- | | | | | |
|---|---|---|--|---|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Digestive Disorders | <input type="checkbox"/> Behavioral Problems | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Neck Problems |
| <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Poor Appetite | <input type="checkbox"/> Stomach Aches | <input type="checkbox"/> Arm Problems | <input type="checkbox"/> Reflux |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Muscle Pain | <input type="checkbox"/> Leg Problems | <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Backaches | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Asthma | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Bed Wetting | <input type="checkbox"/> Walking Trouble | <input type="checkbox"/> Poor Posture | <input type="checkbox"/> Fall from crib |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Chronic Colds | <input type="checkbox"/> Temper Tantrums | <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Colic |
| <input type="checkbox"/> Fall off slide | <input type="checkbox"/> Fall from high chair | <input type="checkbox"/> Fall from bed or couch | <input type="checkbox"/> Fall down stairs | <input type="checkbox"/> Fall in walker |
| <input type="checkbox"/> Fall from changing table | <input type="checkbox"/> Fall off monkey bars | <input type="checkbox"/> 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 hereby 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: ____/____/____

Doctor's Signature _____ Date Form Reviewed: ____/____/____