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:_ Email Address: _____

_____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:_____/_____/_____

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:_____/_____