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: _____ 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:

☐ Headaches	☐ Digestive Disorders	☐ Behaviora l 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 Disorder s 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: _____/_____/_____

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