Childhood Health History

Name _____ Age _____ Birthdate_____

Nickname/Preferred Name you would like us to call you: _____

What is your child's current gender identity? (Check ALL that apply)

☐ Male ☐ Female ☐ Transgender Male/Transman/FTM ☐ Transgender Female/Transwoman/MTF ☐ Gender Queer
☐ Additional category (please specify): _____ ☐ Decline to answer

What sex were you assigned at birth? (Check one)
☐ Male ☐ Female ☐ Other

Address _____City _____ State _____ Zip_____

Telephone (home) _____ (cell) _____

Is it ok to leave a personal detailed message at one of these numbers? Y N which one? _____

Would you like to receive communications by unsecured email? Y N

If yes, what is your email address? _____

Please initial you received a copy of privacy policy _____ and office policy_____

Who lives with your child?_____

Name of Parents: _____

Emergency contact _____ Relationship _____

EC Address _____EC Telephone _____

How did you hear about us? Phone book____ Insurance ____ Internet ____ Referred by_____
Other _____

How would you rate your child's overall health?

Poor Fair Good Excellent

What is your child's top 3 health concerns today?

1. _____ 2. _____ 3. _____

Prescription Medications Child is Currently Taking

(Regularly scheduled and ones taken as needed; there is additional space at end of form if you need it)

Name of Medicine	Dose	How Often You Take It	What You Take It For

Non-Prescription Medications, Vitamins, Herbs, Supplements, Homeopathic Remedies Child is Currently Taking

(Regularly scheduled and ones taken as needed; there is additional space at end of form if you need it)

Name	Dose	How Often You Take It	What You Take It For

Is your child allergic to any foods or medications? _____

_____

Do parents currently smoke? If yes: In the house? In the car?

Immunizations:

What are your thoughts on vaccinations for your child? _____

_____

Has your child had the following vaccines?

Polio	Y	N	Pertussis	Y	N
Tetanus/Diphtheria	Y	N	Hepatitis B	Y	N
Measles/Mumps/Rubella	Y	N	Hepatitis A	Y	N
Hemophilus Influenza	Y	N	Meningitis	Y	N
Pneumococcal (Prevnar)	Y	N	Varicella (Chicken Pox)	Y	N
Rotavirus	Y	N	Other		

Your child's past medical history:

Were there any problems with your child's birth or the mother's pregnancy? _____

_____ _____

Has your child ever been in the hospital overnight? If so, why, and when was it? _____

_____

Has your child ever had any of the following? (√ if yes)

	Now	Past	Never		Now	Past	Never
Allergies				Anemia			
Headache				Heart Murmur			
Asthma				High Blood Pressure			
Kidney Disease				Bleeding Problems			
Liver Disease				Cancer			
Overweight				Candida (yeast)			
Pneumonia				Eczema/rashes			
Injury (serious)				Behavior Problems			
Other							

Is your child currently seeing any other health practitioners?

_____

_____

_____

_____

Family History:

Please list the ages and if deceased, what they died from and at what age.

Mother's side	**Father's side**
Grandfather	Grandfather
Grandmother	Grandmother
Mother	Father
Sisters	Sisters
Brothers	Brothers

Is there anything else you would like to let us know about your child to help us care for him/her better?

_____

_____

_____

_____

_____

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGN BENEFITS I hereby authorize the release of any medical information necessary to in the processing of my medical claim. I also authorize payment directly to Elevate Health for the medical benefits. I authorize my practitioner to examine and treat me, to consult with another healthcare practitioner regarding continuing my care. I certify that the information that I have supplied is correct and accurate to the best of my knowledge.

Signed _____ Date_____

Patient, parent or guardian of minor