Welcome to Hudson Valley Whole Life Center!
Please complete all questions.

Child's Name: _____ Date of birth: _____

Address: _____

Home Telephone: _____ Parent(s) Cell/work Telephone: _____

Pediatrician's Name/Address: _____

Child's Height: _____ Child's Weight: _____

Name of Parent(s) or Guardian(s): _____

What are your chief concerns, if any, with your child's health? _____

_____

_____

What is the main reason for contacting us? _____

_____

List any other care your child has undergone with regards to this complaint including medication: _____

_____

Date of onset (mm/yyyy): _____

Duration of problem/episode (circle one): Minutes Hours Days Months Years

Onset was (circle one): Sudden Gradual Associated with an event

Pattern of problem (circle one): Constant Intermittent Occasional Cyclical

Initiating factors: _____

Aggravating factors: _____

Relieving factors: _____

Current medications: _____

Allergies: _____

How does the problem affect your child's body function and daily activities? _____

_____

Prior occurrence of episodes? _____

_____

Parental Consent for Minor Patient:

Patient Name: _____

Patient age: _____ DOB: _____

Printed name of person legally authorized to sign for

Patient: _____

Signature: _____

Relationship to Patient: _____

In addition, by signing below, I give permission for the above named minor patient to be managed by the doctor even when I am not present to observe such care.

Printed name of person legally authorized to sign for

Patient: _____

Signature: _____

Relationship to Patient: _____

Remarks: _____

_____

_____

Live Your D.R.E.A.M. Life

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