CONCEPT CARE CHIROPRACTIC AND WELLNESS CENTER

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PATIENT INFORMATION **DATE____/____/_____**

Patient Name (last,first)_____ReferredBy:_____

Address_____ City_____ State_____ Zip Code_____

Home Phone_____ Cell #_____ Work #_____

Social Security #_____ Email _____ _____

Date of Birth_____/_____/_____ Sex M / F Height _____feet _____inches Weight _____ lbs

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Mother:_____ Father:_____

What is the child's main problem? _____

_____

_____

When and how did it begin? _____

_____

If he/she is experiencing pain, circle the nature of the pain:
Sharp Dull Comes and Goes Travels Constant

Since the problem began, is it:
About the same Getting better Getting worse

What makes it worse? _____
What makes it better? _____
It interferes with: School, Sleep, Walking, Sitting, Hobbies, Other: _____

General Health Related Information:

How is your child's general health? _____

Behavioral or emotional problems? _____ Explain: _____

_____

Suffer any traumas, such as serious falls (over 3 ft) or car accidents? Yes____ No_____ Explain: _____

_____

Has the child been under regular chiropractic care? Yes_____ No_____

Is child up to date on vaccinations? Yes _____ No _____

Does the child have any allergies? (medication, food, other substances) Yes _____ Explain: _____

_____

Does the child take any medications? (please list the name and dosages, if possible)
(Include all vitamins, herbal supplements and over-the-counter medications)

1. _____ 3._____
2. _____ 4._____

Please give us any other health information that would be helpful: _____

_____

Pregnancy:

Were there any complications to the pregnancy? _____

_____

Was Mom on any medications (prescription or over the counter)? Yes_____ No _____ Explain: _____

_____

Did someone in the house smoke during pregnancy? Yes (who) _____ No _____

Was the baby ever in breech position? Yes_____ No _____

Birth and Delivery:

Where was the baby born? Home Hospital Birthing Center

Was the delivery: Vaginal C-section Were any devices used? Forceps Vacuum

How long was the labor and delivery? _____

Was oxytocin/pitocin used? Yes_____ No _____

Was an epidural administered? Yes _____ No _____

Episotomy needed? Yes _____ No _____

Did mom breastfeed and for how long? Yes (months) _____ No _____

Other information: _____

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