



# Raschke Chiropractic Center, S.C.

Preventive Family Health Care  
Fred W. Raschke, D.C.

## Child's Health History

### Welcome to our Health Center

Dear Parent: Please complete this questionnaire. Your answers will help us determine if we can help your child. If we do not sincerely believe his/her condition will respond satisfactorily, we will not accept his/her case. Thank you!

#### Patient Information

Child's Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Mothers Name: \_\_\_\_\_ Father's Name: \_\_\_\_\_  
Employer/Occupation: \_\_\_\_\_ Employer/Occupation: \_\_\_\_\_  
Address: \_\_\_\_\_  
City/State/Zip: \_\_\_\_\_  
Home Phone: \_\_\_\_\_  
Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_  
Primary Care Physician: \_\_\_\_\_  
Who referred you to our office?  Ad  Billboard  Family/Friend Name \_\_\_\_\_  
 Yellow Pages  Another Doctor Name \_\_\_\_\_

#### History

List the problems or concerns you want us to address starting with the most important.

1. \_\_\_\_\_
2. \_\_\_\_\_

When did the primary problem start? (Exact date if possible) \_\_\_\_\_

What brought it on? \_\_\_\_\_

How often do your child's symptoms occur?  Constant  Frequently  Intermittently  Occasionally  Other \_\_\_\_\_

Is your child getting...  Better  Worse  Staying the same

Did your child ever have problems in this area before? Yes  No

If yes, when and number of episodes? \_\_\_\_\_

#### Birth

Delivery:  Natural  Cesarean  Forceps  Vacuum

Length of Labor: \_\_\_\_\_ Pain Medication During Labor?  Yes  No Weeks Gestation \_\_\_\_\_

Number of Days in Hospital: \_\_\_\_\_ Problems during Pregnancy? \_\_\_\_\_

Problems after birth: \_\_\_\_\_

Birth Weight: \_\_\_\_\_ Length: \_\_\_\_\_ Breast Fed?  Yes  No How Long? \_\_\_\_\_

Birth Order: \_\_\_\_\_ Formula Fed?  Yes  No

#### Additional Information

What age did your child begin walking alone? \_\_\_\_\_ Does your child sleep through the night? \_\_\_\_\_

Is your child Happy?  Fussy?  When? \_\_\_\_\_ Favorite foods: \_\_\_\_\_

Number of antibiotics your child has been on: \_\_\_\_\_

#### Medical History

What other physicians (M.D.'s, and D.C.'s) has your child seen for this problem?

Name	Specialty	Date Seen
_____	_____	_____
_____	_____	_____

**Past Medical History**

**Pleas list any medical problems your child has been diagnosed with**

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**Please list previous surgeries**

**Reason**

**Date Performed**

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**Please list previous accidents & hospitalizations**

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**Please list all medications that your child presently takes (prescription & non-prescription)**

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**Does your child take any nutritional supplements?**

Yes No

\_\_\_ Multi-Vitamin

\_\_\_ Flax/Fish Oil

\_\_\_ Antioxidant

\_\_\_ Other \_\_\_\_\_

**Allergies**

**Food/Seasonal:** \_\_\_\_\_

**Medications/Reactions:** \_\_\_\_\_

**Personal / Social History**

**Please list your child's hobbies/sports:**

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**Is there anything else you would like us to know about your child's health?**

Yes No

**If yes, please explain** \_\_\_\_\_

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I acknowledge that I have been given a copy of the Notice of Privacy document on \_\_\_\_\_(date),

\_\_\_\_\_ (Signature)

Thank you for completing this questionnaire. Guardian's signature is required when under 18 years of age. Signature implies consent to treatment.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Doctor's Signature

\_\_\_\_\_  
Date