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 <u>for this problem</u>?

Name Specialty Date Seen

_____
_____

Past Medical History

Pleas list any medical problems your child has been diagnosed with

_____

_____

Please list previous surgeries **Reason** **Date Performed**

_____

_____

_____

Please list previous accidents & hospitalizations

_____

_____

_____

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

_____

_____

Does your child take any nutritional supplements? Yes No

___ Multi-Vitamin ___ Flax/Fish Oil ___Antioxidant ___ Other _____

Allergies

F**ood/Seasonal:** _____

Medications/Reactions: _____

Personal / Social History

Please list your child's hobbies/sports:

_____

_____

Is there anything else you would like us to know about your child's health? Yes No

If yes, please explain_____

_____

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