CHILDREN'S SURVEY

Parent's Name: ______________________________

Address: ___________________________________

____

Child's Name: _________________ Age: _________

Phone: _____________________________________
(ONLY if you would like a phone consultation.)

REGARDING YOUR CHILD

Were there any complications in your pregnancy or delivery?	Yes	No
Was your child born by C-Section?	Yes	No
Did the doctor use forceps or other device for delivery?	Yes	No
Did your child have early health challenges such as colic?	Yes	No
Did (or does) your child have ear infections frequently?	Yes	No
Did your child have any falls that concerned you?	Yes	No
Does your child complain of headaches, neck pain, or back pain?	Yes	No
Does your child have allergies?	Yes	No
Does your child have a problem with bed-wetting?	Yes	No
Does your child have difficulty concentrating?	Yes	No
Does your child have frequent temper tantrums?	Yes	No
Are there any other health problems that concern you?	Yes	No
Has your child's posture been examined?	Yes	No
If so, when?	______________	

REGARDING YOUR RELATIONSHIP WITH YOUR CHILD

Do you miss work often due to your child's illnesses?	Yes	No
Do you miss sleep often due to your child's illnesses?	Yes	No
Do you worry often about your child's health?	Yes	No
Do <u>you</u> have health problems that affect your family?	Yes	No
Are aches and pains preventing you from taking part in family activities?	Yes	No