CHILD HEALTH SURVEY

DEBOLE CHIROPRACTIC

Child's Name _____ DOB _____

Parent's Name _____

Address _____City, State, Zip _____

Phone _____

REGARDING YOUR CHILD

Were there any complications in your pregnancy or delivery? Y N

Was your child born by C-Section? Y N

How long was the actual labor and delivery time? _____

Did the doctor use forceps or other devices for delivery? Y N

Did your child have early health challenges such as colic? Y N

Did [or does] your child have ear infections frequently? Y N

Did your child have any spills or falls that concerned you? Please explain. _____

Does your child have allergies, asthma, or sinus problems? Y N

Does your child have a problem bed wetting? Y N

Does your child have difficulty concentrating? Y N

Does your child have frequent temper tantrums? Y N

Are there any other health problems that concern you? Y N

REGARDING YOUR RELATIONSHIP WITH YOUR CHILD

Do you miss work often due to your child's illnesses? Y N

Do you miss sleep often due to your child's illnesses? Y N

Do you worry often about your child's health? Y N

Do you have health problems that affect your family? Y N

Are aches and pains preventing you from taking part in family activities? Y N

What medication[s] does your child take regularly or frequently? Y N

Parent/Guardian Signature _____ Date _____