Bridges
Chiropractic Health Clinic

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PEDIATRIC FUNCTIONAL FORM (Age 2+)

Today's Date: _____

Child's Name: _____ Date of Birth:_____

Please check all those that apply to your child:

_____ 1. Has your child complained of any pain or discomfort?

_____ 2. Has your child complained of any headaches?

_____ 3. Does your child ever dislike light or sound?

_____ 4. Has your child fallen/tripped/tumbled/hit their head etc.?

_____ 5. Has your child been more irritable, easily upset, or throwing tantrums?

_____ 6. Does your child have difficulty falling asleep or staying asleep?

_____ 7. Has your child struggled with digestion? Please circle: Diarrhea Constipation Reflux Bloating Pain

_____ 8. Does your child avoid certain textures/flavors of foods?

_____ 9. Does your child struggle with balance and/or coordination?

_____ 10. Does your child have bad posture, walk on their toes, or sit in a W position?

_____ 11. Has your child had any illness/fever/infection(s) in the past few months?

_____ 12. Has your child had any allergies/eczema/asthma?

_____ 13. Has your child ever struggled with ear infections? How many have they had? _____

_____ 14. Does your child struggle with learning or retaining information?

_____ 15. Does your child have difficulty with math or reading?

_____ 16. Does your child struggle with handwriting?

_____ 17. Does your child struggle with focus/sitting still or are they easily distracted/fidgeting often?

_____ 18. Would you describe your child as shy or do they have any anxiety?

_____ 19. Does your child ever get car sick or motion sickness?

_____ 20. Was your child born via C-section or induced birth?

See back ->

_____ 21. Did your child crawl abnormally (i.e. bear walk, crab crawl, army crawl, etc.)?

At what age did they start crawling? _____ What age did they start walking? _____

_____ 22. Does your child have difficulty with speech or ever had delayed speech (i.e. nonvocal at 1 year old)?

_____ 23. Does your child wear pull ups/diapers at night or wet the bed?

_____ 24. Have you noticed any change in relationships with grandparents/daycare providers/teachers?

Score: _____/24

Surgeries/Injuries/Hospitalizations: _____

Medications/Supplements: _____

Other Concerns: _____

This form was completed by: _____

Relation to child: _____

Signature: _____