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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? (Please circle)
- _____ 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 anxiety?
- _____ 19. Does your child ever get car sick or motion sickness?
- _____ 20. Please circle all that apply for your child's birth: C-section Emergency C-section Vaginal
Pitocin Cytotec Breech Use of Forceps Use of Vacuum Born at how many weeks? _____
Active Labor approximately how many hours: _____

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 struggle with bed wetting?

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

Vaccines (please circle): Covid-19 All on schedule All with delayed schedule Some None

Surgeries/Injuries/Hospitalizations: _____

Medications/Supplements: _____

Typical Daily foods consumed: _____

Other Concerns: _____

This form was completed by: _____

Relation to child: _____

Signature: _____