

CHILD HEALTH SURVEY

Child's Name _____ Date of Birth _____

Parent's Name _____

Address _____

City _____ State _____ Zip _____

Phone Number _____ E-mail _____

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/Does your child have ear infections frequently? Y N

Did your child have any spills or falls that concerned you? Y N

If yes, please explain: _____

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

Does your child have a bed-wetting problem? 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

If yes, please explain: _____

REGARDING YOUR RELATIONSHIP WITH YOUR CHILD

Do you miss work 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 pains preventing you from taking part in family activities? Y N

What medication(s) (if any) does your child take regularly or frequently? _____

Parent Guardian Signature _____ Date _____