

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 _____