Child Health Questionnaire

Please print clearly:

Child's Name_____ Age___ Date of Birth_____

Parent's Name_____ Address_____

City_____ State_____ Zip_____

Home phone_____ Work phone_____

Does your child suffer any of the following health problems?

(Circle all that apply)

headaches allergies ear problems sleep disorders fatigue

breathing problems irritability hyperactivity frequent colds

flu bloody noses asthma diarrhea constipation colic

rashes bed-wetting milk or lactose-intolerant food allergies

learning disorders twitching excessive talking to himself / herself

Other _____

Nutritional supplements your child takes_____

Medications currently on_____

List any surgery / operations (with approx. dates)_____

_____

Past accidents / injuries_____

If you could improve one aspect of your child's health or behavior, what would it be?

_____

Parent's signature authorizing care _____

Date _____