Lancaster Chiropractic Life Center
1668 Lincoln Highway East, Lancaster, PA 17602

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 deliver?	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 deliver?	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 _____