Baby/Toddler (0-3): have/did any of the following occur?

☐ Fall from a changing table	☐ Frequent crying spells
☐ Tumble down stairs	☐ Frequent fevers
☐ Fall out of a crib	☐ Frequent bouts of diarrhea
☐ Involvement in MVA	☐ Constipation
☐ Fall off playground equipment	☐ Sleeping Problems
☐ Play in a Johnny jumper	☐ Repeated infections or colds
☐ Frequent ear infections	☐ Colic
☐ Tonsillitis	☐ Inadequate weight gain
☐ Reaction to vaccines	☐ Other:_____

Child (5-8): have /did any of the following occur?

☐ Fall from a tree	☐ Fall on playground
☐ Fall off a bicycle	☐ Hyperactivity/autism
☐ Sports Accident	☐ Learning difficulties
☐ Stomach pains	☐ Asthma
☐ Scoliosis	☐ Allergies
☐ Bed Wetting	☐ Leg/knee pains
	☐ Other:_____

Which sports does your child play?

☐ Soccer	☐ Basketball
☐ Football	☐ Dance
☐ Gymnastics	☐ Wrestling
☐ Karate	☐ Baseball/ Softball
☐ Hockey	☐ Volleyball
☐ Lacrosse	☐ Tennis
☐ Rugby	☐ Swimming
☐ Other:_____	

Which of the above bothers your child the most?_____

When did it begin?_____ Is it getting worse? ☐YES ☐NO

Is the pain : ☐constant ☐intermittent ☐cyclic

How much has the complaint affect daily activities/routines? ☐ Not at all ☐Somewhat ☐Frequently ☐ Always

How would you rate your child's diet? ☐Well Balanced ☐ Average ☐High amount of sugar

Does your child consume artificial sweeteners? ☐YES ☐ NO Fluoridated water? ☐YES ☐ NO

Number of hours your child sleeps? _____/day Quality: ☐GOOD ☐FAIR ☐ POOR

Is there anything else we should know about your child?

_____