Children's Symptom Survey

Name: ____________________ Today's Date: ______________ Age: ________ Approx. Weight: _______

Sleep Quality (circle one)
Poor, Fair, Good, Great

Sleep (check all that apply)
- ☐ Difficulty falling asleep
- ☐ Difficulty staying asleep
- ☐ Bedwetting
- ☐ Jolt Awake
- ☐ Nightmares

# of hours in bed _____
# of hours asleep _____
# of interruptions/night _____

Emotions/Behavior (check all that apply)
- ☐ Stress
- ☐ Sadness
- ☐ Grief
- ☐ Depression
- ☐ Moodiness
- ☐ Frustration
- ☐ Irritability
- ☐ Anger
- ☐ Nervousness
- ☐ Anxiety
- ☐ Panic
- ☐ Fear
- ☐ Shame
- ☐ Guilt
- ☐ Rebelliousness
- ☐ Frequent tantrums
- ☐ Frequent crying
- ☐ Hyperactivity
- ☐ Difficulty concentrating

Has Your Child Been Tested for Toxic Metal Exposure via hair mineral analysis? (lead, arsenic, etc.) Circle: Y or N

Does Your Child Receive Regular Chiropractic Care?
Circle: Y or N

Appetite (circle one)
Low, Normal, High, Varies

Diet (check all that apply)
- ☐ Sweet/starch cravings
- ☐ Excessive thirst

My Child Consumes:
Animal protein ____ times/wk
Pasta/Bread/Cereal/Milk ____ times/wk
Sweets ____ times/wk
Soda ____ times/wk
Artificial colors (Goldfish, Gatorade, Doritos, etc.) ____ times/wk
Juice ____ times/wk

Eyes (check all that apply)
- ☐ Eye Film
- ☐ Morning crustiness
- ☐ Itchiness
- ☐ Blurry vision

Ears (check all that apply)
- ☐ Ear Aches/ Infections
  Left, right, or both (Circle)
  Treated with antibiotics?
- ☐ Internal itchiness
- ☐ Excessive wax

Sinus (check all that apply)
- ☐ Frequent sneezing
- ☐ Sinus pressure
- ☐ Frequent or prolonged sinus drainage

Date and Type of Last Vaccination ______________
____

If Child is Under Age 3, Type of Formula ______________
____

Lungs (check all that apply)
- ☐ Wheezing
- ☐ Asthma
- ☐ Chest congestion
- ☐ Bronchitis
- ☐ Cough (dry, productive)

Mouth (check all that apply)
- ☐ Teeth problems/Cavities
- ☐ Swollen glands
- ☐ Sore throat
- ☐ Hoarseness
- ☐ Fever
- ☐ Adenoids removed
- ☐ Tonsils removed

Bladder (check all that apply)
- ☐ Accidents at school
- ☐ Urination urgency
- ☐ Burning/Pain
- ☐ Cloudy urine

Skin (check all that apply)
- ☐ Rash
- ☐ Itchiness
- ☐ Molluscum
- ☐ Dryness
- ☐ Eczema
- ☐ Psoriasis
- ☐ Bumps on back of arms

Stomach (check all that apply)
- ☐ Chronic stomach aches
- ☐ Gas/Flatulence
- ☐ Bloating
- ☐ Frequent vomiting
- ☐ Reflux

Bowels (check all that apply)
- ☐ Incomplete movements
- ☐ Skipping days

# of movements/day _______

Fecal Consistency (circle all that apply)
Soft, Hard, Pebbles, Painful Diarrhea, Constipation, Itchy Bottom

***Typical color**: (circle one)*
Light, Normal, Dark

Activity Level (Circle one)
Low, Normal, High

Conditions/Diagnoses (Mark age of onset, add additional details below if necessary)
- ☐ ADD/ ADHD
- ☐ Chicken Pox
- ☐ Colic
- ☐ Congenital defects
- ☐ Digestive Problems
- ☐ Fever Blisters
- ☐ Frequent colds/flu
- ☐ Headaches/Migraines
- ☐ Jaundice
- ☐ Measles
- ☐ Mumps
- ☐ Pneumonia
- ☐ Seasonal Allergies
- ☐ Skin Disorders
- ☐ Strep Infections
- ☐ Tonsillitis
- ☐ Whooping cough
- ☐ Other(describe):

Food Allergies
____
____
____

Environmental Allergies
____
____

List/Describe Any Additional Information or Concerns Not Covered in the Above Checklist:
____
____
____
____
____
____
____

List Your Child's Top Health Concerns:
____
____
____
____
____
____

Recent Medication History
____
____
____
____
____
____

Dr. Use Only

Eyes	Nails	Tongue
Puffy	White spots	Color
Dark Circles	Weak peeling	Swelling
	Discoloration	Dark veins