PRESENT HEALTH COMPLAINTS &/OR CONCERNS:

Primary Complaint:_____

Secondary/Minor Complaint:_____

When did this problem begin?_____

Is this problem (circle): ***occasional*** ***frequent*** ***constant*** ***intermittent***

Is it a radiating problem? ***Yes*** ***No*** ***If Yes,*** to where does it radiate? _____

What makes the problem worse?_____

What makes it better?_____

Is the problem worse during a certain time of the day? ***Yes*** ***No***

If Yes, when? _____

Does this interfere with the child's sleep?_____eating?_____daily routine?_____

Is this becoming worse?_____

Has your child seen other professionals for this condition? ***Yes*** ***No***

If Yes, who did the child see? _____

What were the results of the recommended treatment?_____

Often, seemingly unrelated symptoms can manifest as other health concerns. Please mark next to each symptom that your child has had:

__headaches
__dizzinesss
__fainting
__fatigue
__irritability
__depression
__loss of balance
__loss of concentration
__loss of memory
__ears buzzing
__poor coordination
__vision changes
__loss of smell

__loss of taste
__light sensitivity
__face flushed
__cold sweats
__bronchitis
__pneumonia
__difficulty breathing
__shortness of breath
__asthma
__urinary problems
__constipation
__diarrhea
__weight loss

__weight gain
__dental problems
__fevers
__heart palpitations
__chest pressure
__breast pain
__frequent colds
__sinus congestion
__sore throats
__ear pain/infections
__allergies
__heartburn
__bloating/gas

__upper back pain
__neck pain
__low back pain
__radiating pain
__stiffness
__reduced mobility
__numbness in leg(s)
__numbness in feet
__numbness in hand(s)
__weakness
__muscle cramps
__sleeping problems

__other:_____