Back & Neck Clinic
OF NEW PRAGUE

Infant Functional Form

Child's Name: _____ Today's Date: _____

Weight: _____ Height: _____

Please check all that applies to your child.

_____1. Has your child been more irritable/less consolable?

_____2. Has your child had difficulty sleeping?

_____3. Has your child's sleeping patterns changed?

_____4. Has your child's digestion pattern changed? (i.e. constipation/diarrhea)

_____5. Has your child's intake of food been less or more?

_____6. Has your child needed more parental attention/affection?

_____7. Has your child been more distant/less affectionate?

_____8. Has your child had trouble with nursing or taking a bottle?

_____ 9. Has your child had a developmental milestone and then lost it? (i.e. able to roll over and now no longer can do so?)

_____ 10. Has your child shown unwarranted emotions such as fear?

_____ 11. Has your child shown a new physical issue (i.e. sucking their thumb or blanket) for comfort?

_____12. Has a normal daily activity shown change (i.e. cries now when put in car seat)?

_____13. Have any normal play patterns changed?

_____14. Have you noticed any changes in relationships with grandparents/daycare providers?

_____ Score

(952) 758-5135
201 E Main St
New Prague, MN 56071