Back & Neck Clinic
OF NEW PRAGUE

Pediatric 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?

_____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 learning or retaining information?

_____9. Has your child's attention or focus been shortened?

_____10. Has your child's balance or coordination been altered?

_____11. Have you noticed any changes in speech patterns?

_____12. Have you noticed any changes in breathing patterns?

_____13. Have you noticed any visional changes such as squinting?

_____14. Have you noticed a change in "playing" patterns?

_____15. Have you noticed any aggression/violence/acting out?

_____16. Have you noticed any changes in relationships with grandparents/daycare providers?

_____ Score

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