



Had Colic	Yes	<input type="checkbox"/>		
	No	<input type="checkbox"/>		
Antibiotics Taken	1x	<input type="checkbox"/>	2x	<input type="checkbox"/>
			3x	<input type="checkbox"/>
Ear Infections	Yes	<input type="checkbox"/>		
	No	<input type="checkbox"/>		
Bed Wetter	Yes	<input type="checkbox"/>		
	No	<input type="checkbox"/>		
Asthma	Yes	<input type="checkbox"/>	Ventolin	<input type="checkbox"/>
	No	<input type="checkbox"/>	Becotide	<input type="checkbox"/>
Family History of Scoliosis	Yes	<input type="checkbox"/>		
	No	<input type="checkbox"/>		
Poor School Performance	Yes	<input type="checkbox"/>		
	No	<input type="checkbox"/>		
Moves bowels every day	Yes	<input type="checkbox"/>		
	No	<input type="checkbox"/>		
Aggressive	Yes	<input type="checkbox"/>		
	No	<input type="checkbox"/>		
Drinks Water	< 2 glasses per day	<input type="checkbox"/>		
	3-5 glasses per day	<input type="checkbox"/>		
	+ 5 glasses per day	<input type="checkbox"/>		
Fizzy drinks	Yes	<input type="checkbox"/>		
	No	<input type="checkbox"/>		
Eats Vegetables	Poor	<input type="checkbox"/>		
	Good	<input type="checkbox"/>		
	Excellent	<input type="checkbox"/>		

Vaccinated

Yes

Reactions.....

No .....

Fractures

Yes

No

What part of the body.....

Accidents ( falls, car, bike, stairs etc ) .....

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Any concerns you have about your child .....

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Parent / Guardian consent for spinal check .....

Date .....