Edgecliff Physiotherapy Sports & Spinal Centre
"Key Moves 4 Kids"®
Therapeutic Exercise Classes

Questionnaire

Does your child experience joint pains/muscle aches? Y/N

Please specify.

Does your child experience growing pains? Y/N

Does your child experience headaches? Y/N

Does your child experience frequent falls or accidents? Y/N

Does your child have poor balance? Y/N

Does your child have difficulty hopping on 1 leg? Y/N

Does your child have poor pencil grip/writing position? Y/N

Does your child experience difficulty in sitting still? Y/N

Does your child experience car/motion sickness? Y/N

Does your child experience dizziness readily? Y/N

Did your child experience any difficulties at birth? Y/N

Please specify.

Did your child achieve sequential developmental mile stones; prone lying, rolling, sitting, crawling, cruising, and then walking? Y/N

Please specify.

Does your child experience difficulties with hearing, sight, allergies or hypersensitivities? Y/N

Please specify.