Questionnaire on the development of the child	Yes	No
Has there been any abnormality of physical or psychological origin during pregnancy?		
Were there any complications during the birth? (forceps / suction cup / umbilical cord around the neck / other)		
Has your child been born more than 2 weeks before the expected date of birth?		
Was your child born by cesarean section? (Desired cesarean section? Emergency cesarean section? Medically planned cesarean section).		
Was the birth process unusually long / short?		
Was labor promoted/inhibited by medication?		
Did your child lie predominantly on its back during the first months?		
Is your child particularly sensitive to sounds?		
... to touch?		
... to brightness / light?		
Is your child easily frightened?		
Does he/she suffer from above-average separation anxiety?		
Is your child afraid of school and even shows physical symptoms? (stomach ache / nausea)		
Does your child have difficulty writing dictations?		
Does your child hold the pen in a cramped manner?		
Does your child tire quickly when writing?		
Does your child make mouth / tongue movements when writing or clench his/her teeth?		
Does your child speak unclearly?		
Does your child curl his/her toes?		
Does your child predominantly walk on tiptoes?		
Does your child frequently rest his/her head in at least one hand when sitting?		
Does your child tend to "slouch" when sitting?		
Does your child have balance problems?		
Does your child have difficulty copying from the blackboard or books?		
Does your child feel sick when driving? (Travel sickness)		
Does your child write in mirror writing or mix up the letters b and d?		
Does your child have a poor sense of direction?		
Are oral grades at school generally better than written grades?		

Child's name:____________________

Age_______

Questionnaire on the development of the child	Yes	No
Does your child put the paper / notebook crooked in front of him/her to write?		
Is your child very impulsive and gets angry easily?		
Does your child have difficulty understanding what he/she reads or does he/she read too slowly?		
Has your child been wetting the bed at night for longer than 5 years?		
Is your child generally scatterbrained, disorganized or forgetful?		
Has your child walked directly/has he/she skipped crawling?		
Does your child sit on the chair on one foot or both feet?		
Does your child wrap his/her legs around the chair legs when sitting?		
Does your child have trouble catching a ball?		
Does your child have difficulty learning to swim?		
Does your child have difficulty sitting still?		
Does your child need a routine?		
Is your child easily distracted?		
Does your child have asthma? Allergies? Does he/she have frequent colds?		
Is your child often whiny?		
Does your child have difficulty concentrating?		
Does your child have excessive salivation?		
Has your child been sucking thumbs / taking pacifiers for a relatively long time?		

Age ______

Child's name ______________

Please send the completed questionnaire to your contact:in for KinFlex® Reflex Therapy prior to treatment.

If there are at least 5 yes-answers, it is worth making an appointment :-)

KinFlex® Reflex Therapy-
Promote reflex development - release potentials!