



# Well Life

FAMILY MEDICINE

## Pediatric Health Questionnaires

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**GENERAL INFORMATION**

Name *First* \_\_\_\_\_ *Middle* \_\_\_\_\_ *Last* \_\_\_\_\_

Preferred Name \_\_\_\_\_

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Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Gender  Male  Female

Genetic Background  African  European  Native American  Mediterranean  
 Asian  Ashkenazi  Middle Eastern  \_\_\_\_\_

Mother's Name \_\_\_\_\_ Occupation \_\_\_\_\_

Father's Name \_\_\_\_\_ Occupation \_\_\_\_\_

*Person completing this questionnaire*

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Primary Address *Number, Street* \_\_\_\_\_ *Apt. No.* \_\_\_\_\_  
*City* \_\_\_\_\_ *State* \_\_\_\_\_ *Zip* \_\_\_\_\_

Home Phone \_\_\_\_\_ Parent's Work Phone \_\_\_\_\_

Parent's Cell Phone \_\_\_\_\_ Fax \_\_\_\_\_

Email \_\_\_\_\_

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Emergency Contact *Name* \_\_\_\_\_ *Phone Number* \_\_\_\_\_  
*Address* \_\_\_\_\_ *Apt. No.* \_\_\_\_\_  
*City* \_\_\_\_\_ *State* \_\_\_\_\_ *Zip* \_\_\_\_\_

Referred by  Website  Friend or Family Member \_\_\_\_\_  
 Phonebook  Other \_\_\_\_\_

**PHARMACY INFORMATION**

Primary Pharmacy *Name* \_\_\_\_\_ *Phone Number* \_\_\_\_\_  
*Address* \_\_\_\_\_  
*City* \_\_\_\_\_ *State* \_\_\_\_\_ *Zip* \_\_\_\_\_  
*E-mail* \_\_\_\_\_ *Fax\** \_\_\_\_\_

*\* It is extremely important that you list the pharmacy's fax number.*

# Pediatric Medical Questionnaire

## ALLERGIES

| Medication/Supplement/Food | Reaction |
|----------------------------|----------|
| _____                      | _____    |
| _____                      | _____    |
| _____                      | _____    |
| _____                      | _____    |

## COMPLAINTS/CONCERNS

What do you hope to achieve in your visit with us? \_\_\_\_\_

If you had a magic wand and could help your child in three ways, what would they be?

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

When was the last time you felt your child was well? \_\_\_\_\_

Did something trigger your child's change in health? \_\_\_\_\_

Is there anything that makes your child feel worse? \_\_\_\_\_

Is there anything that makes your child feel better? \_\_\_\_\_

Please list current and ongoing problems in order of priority:

| Describe Problem                                 | Success |          |        | Prior Treatment/Approach | Success   |      |      |
|--|---------|----------|--------|--------------------------|-----------|------|------|
|  | Mild    | Moderate | Severe |                          | Excellent | Good | Fair |
| <i>Example: Difficulty Maintaining Attention</i> |         | X        |        | <i>Elimination Diet</i>  | X         |      |      |
| _____  |         |          |        |                          |           |      |      |
| _____  |         |          |        |                          |           |      |      |
| _____  |         |          |        |                          |           |      |      |
| _____  |         |          |        |                          |           |      |      |
| _____  |         |          |        |                          |           |      |      |
| _____  |         |          |        |                          |           |      |      |

# MEDICAL HISTORY

**DISEASES/DIAGNOSIS/CONDITIONS** *Check appropriate box and provide date of onset*

| PAST                     | CURRENT                  | GASTROINTESTINAL                        |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Irritable Bowel Syndrome _____          |
| <input type="checkbox"/> | <input type="checkbox"/> | Inflammatory Bowel Disease _____        |
| <input type="checkbox"/> | <input type="checkbox"/> | Crohn's _____                           |
| <input type="checkbox"/> | <input type="checkbox"/> | Ulcerative Colitis _____                |
| <input type="checkbox"/> | <input type="checkbox"/> | Gastritis or Peptic Ulcer Disease _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | GERD (reflux) _____                     |
| <input type="checkbox"/> | <input type="checkbox"/> | Celiac Disease _____                    |
| <input type="checkbox"/> | <input type="checkbox"/> | Other _____                             |

| PAST                     | CURRENT                  | CARDIOVASCULAR                           |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Disease _____                      |
| <input type="checkbox"/> | <input type="checkbox"/> | Elevated Cholesterol _____               |
| <input type="checkbox"/> | <input type="checkbox"/> | Hypertension (high blood pressure) _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Rheumatic Fever _____                    |
| <input type="checkbox"/> | <input type="checkbox"/> | Mitral Valve Prolapse _____              |
| <input type="checkbox"/> | <input type="checkbox"/> | Other _____                              |

| PAST                     | CURRENT                  | METABOLIC/ENDOCRINE  |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Type 1 Diabetes _____  |
| <input type="checkbox"/> | <input type="checkbox"/> | Type 2 Diabetes _____  |
| <input type="checkbox"/> | <input type="checkbox"/> | Hypoglycemia _____   |
| <input type="checkbox"/> | <input type="checkbox"/> | Metabolic Syndrome _____<br>(Insulin Resistance or Pre-Diabetes) |
| <input type="checkbox"/> | <input type="checkbox"/> | Hypothyroidism (low thyroid) _____                               |
| <input type="checkbox"/> | <input type="checkbox"/> | Hyperthyroidism (overactive thyroid) _____                       |
| <input type="checkbox"/> | <input type="checkbox"/> | Endocrine Problems _____   |
| <input type="checkbox"/> | <input type="checkbox"/> | Polycystic Ovarian Syndrome (PCOS) _____                         |
| <input type="checkbox"/> | <input type="checkbox"/> | Weight Gain _____  |
| <input type="checkbox"/> | <input type="checkbox"/> | Weight Loss _____  |
| <input type="checkbox"/> | <input type="checkbox"/> | Frequent Weight Fluctuations _____                               |
| <input type="checkbox"/> | <input type="checkbox"/> | Bulimia _____  |
| <input type="checkbox"/> | <input type="checkbox"/> | Anorexia _____   |
| <input type="checkbox"/> | <input type="checkbox"/> | Binge Eating Disorder _____                                      |
| <input type="checkbox"/> | <input type="checkbox"/> | Night Eating Syndrome _____                                      |
| <input type="checkbox"/> | <input type="checkbox"/> | Eating Disorder (non-specific) _____                             |
| <input type="checkbox"/> | <input type="checkbox"/> | Other _____  |

| PAST                     | CURRENT                  | CANCER |
|--------------------------|--------------------------|--------|
| <input type="checkbox"/> | <input type="checkbox"/> | _____  |

| PAST                     | CURRENT                  | GENITAL AND URINARY SYSTEMS    |
|--------------------------|--------------------------|--------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Kidney Stones _____            |
| <input type="checkbox"/> | <input type="checkbox"/> | Urinary Tract Infections _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Yeast Infections _____         |
| <input type="checkbox"/> | <input type="checkbox"/> | Other _____                    |

| PAST                     | CURRENT                  | MUSCULOSKELETAL/PAIN |
|--------------------------|--------------------------|----------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Arthritis _____      |
| <input type="checkbox"/> | <input type="checkbox"/> | Fibromyalgia _____   |
| <input type="checkbox"/> | <input type="checkbox"/> | Chronic Pain _____   |
| <input type="checkbox"/> | <input type="checkbox"/> | Other _____          |

| PAST                     | CURRENT                  | INFLAMMATORY/AUTOIMMUNE                             |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Chronic Fatigue Syndrome _____                      |
| <input type="checkbox"/> | <input type="checkbox"/> | Autoimmune Disease _____                            |
| <input type="checkbox"/> | <input type="checkbox"/> | Rheumatoid Arthritis _____                          |
| <input type="checkbox"/> | <input type="checkbox"/> | Lupus SLE _____                                     |
| <input type="checkbox"/> | <input type="checkbox"/> | Immune Deficiency Disease _____                     |
| <input type="checkbox"/> | <input type="checkbox"/> | Severe Infectious Disease _____                     |
| <input type="checkbox"/> | <input type="checkbox"/> | Poor Immune Function _____<br>(frequent infections) |
| <input type="checkbox"/> | <input type="checkbox"/> | Food Allergies _____                                |
| <input type="checkbox"/> | <input type="checkbox"/> | Environmental Allergies _____                       |
| <input type="checkbox"/> | <input type="checkbox"/> | Multiple Chemical Sensitivities _____               |
| <input type="checkbox"/> | <input type="checkbox"/> | Latex Allergy _____                                 |
| <input type="checkbox"/> | <input type="checkbox"/> | Other _____   |

| PAST                     | CURRENT                  | RESPIRATORY DISEASES                        |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Frequent Ear Infections _____               |
| <input type="checkbox"/> | <input type="checkbox"/> | Frequent Upper Respiratory Infections _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma _____                                |
| <input type="checkbox"/> | <input type="checkbox"/> | Chronic Sinusitis _____                     |
| <input type="checkbox"/> | <input type="checkbox"/> | Bronchitis _____                            |
| <input type="checkbox"/> | <input type="checkbox"/> | Sleep Apnea _____                           |
| <input type="checkbox"/> | <input type="checkbox"/> | Other _____                                 |

| PAST                     | CURRENT                  | SKIN DISEASES   |
|--------------------------|--------------------------|-----------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Eczema _____    |
| <input type="checkbox"/> | <input type="checkbox"/> | Psoriasis _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Acne _____      |
| <input type="checkbox"/> | <input type="checkbox"/> | Other _____     |

# MEDICAL HISTORY (CONTINUED)

PAST | CURRENT **NEUROLOGIC/MOOD**

- Depression \_\_\_\_\_
- Anxiety \_\_\_\_\_
- Bipolar Disorder \_\_\_\_\_
- Schizophrenia \_\_\_\_\_
- Headaches \_\_\_\_\_
- Migraines \_\_\_\_\_
- ADD/ADHD \_\_\_\_\_

- Sensory Integrative Disorder \_\_\_\_\_
- Autism \_\_\_\_\_
- Mild Cognitive Impairment \_\_\_\_\_
- Multiple Sclerosis \_\_\_\_\_
- ALS \_\_\_\_\_
- Seizures \_\_\_\_\_
- Other Neurological Problems \_\_\_\_\_

**PREVIOUS EVALUATIONS**

*Check box if yes and provide date*

- Full Physical Exam \_\_\_\_\_
- Psychological Evaluations \_\_\_\_\_
- Wechsler Preschool & Primary Scale of Intelligence \_\_\_\_\_
- Speech and Language Evaluations \_\_\_\_\_
- Genetic Evaluation \_\_\_\_\_
- Neurological Evaluations \_\_\_\_\_
- Gastroenterology Evaluations \_\_\_\_\_
- Celiac/Gluten Testing \_\_\_\_\_
- Allergy Evaluation \_\_\_\_\_
- Nutritional Evaluation \_\_\_\_\_
- Auditory Evaluation \_\_\_\_\_
- Vision Evaluation \_\_\_\_\_
- Osteopathic \_\_\_\_\_
- Acupuncture \_\_\_\_\_
- Physical Therapy \_\_\_\_\_
- Occupational Therapy \_\_\_\_\_
- Sensory Integration Therapy \_\_\_\_\_
- Language Classes \_\_\_\_\_
- Sign Language \_\_\_\_\_
- Homeopathic \_\_\_\_\_
- Naturopathic \_\_\_\_\_
- Craniosacral \_\_\_\_\_
- Chiropractic \_\_\_\_\_

- MRI \_\_\_\_\_
- CT Scan \_\_\_\_\_
- Upper Endoscopy \_\_\_\_\_
- Upper GI Series \_\_\_\_\_
- Ultrasound \_\_\_\_\_

**INJURIES**

*Check box if yes and provide date*

- Back Injury \_\_\_\_\_
- Neck Injury \_\_\_\_\_
- Head Injury \_\_\_\_\_
- Broken Bones \_\_\_\_\_
- Other \_\_\_\_\_

**SURGERIES**

*Check box if yes and provide date*

- Appendectomy \_\_\_\_\_
- Circumcision \_\_\_\_\_
- Hernia \_\_\_\_\_
- Tonsils \_\_\_\_\_
- Adenoids \_\_\_\_\_
- Dental Surgery \_\_\_\_\_
- Tubes in Ears \_\_\_\_\_
- Other \_\_\_\_\_

**BLOOD TYPE:**  A  B  AB  O  
 Rh+  Unknown

**HOSPITALIZATIONS**  None

| Date | Reason |
|------|--------|
|      |        |
|      |        |
|      |        |
|      |        |

**IMMUNIZATIONS**

Is your child up to date with immunizations?  Yes  No

Do you feel immunizations have had an impact on your child’s health?  Yes  No

If relevant, attach a copy of your child’s immunization record or see addendum.

**PSYCHOSOCIAL**

Has your child experienced any major life changes that may have impacted his/her health?  Yes  No

Has your child ever experienced any major losses?  Yes  No

**STRESS/COPING**

Have you ever sought counseling for your child?  Yes  No

Is your child or family currently in therapy?  Yes  No Describe: \_\_\_\_\_

Does your child have a favorite toy or object?  Yes  No

Does your child practice stress release methods?  Yes  No If yes, then check all that apply:

Yoga  Meditation  Imagery  Breathing  Tai Chi  Prayer  Other: \_\_\_\_\_

Has your child ever been abused, a victim of a crime, or experienced a significant trauma?  Yes  No

**SLEEP/REST**

Average number of hours your child sleeps per night:  >12  10-12  8-10  < 8

Does your child have trouble falling asleep?  Yes  No

Does your child feel rested upon awakening?  Yes  No

Does your child snore?  Yes  No

**ROLES/RELATIONSHIP**

List Family Members:

| Family Member and Relationship | Age | Gender |
|--------------------------------|-----|--------|
|                                |     |        |
|                                |     |        |
|                                |     |        |
|                                |     |        |
|                                |     |        |
|                                |     |        |

Who are the main people who care for your child? \_\_\_\_\_

Their employment/occupation: \_\_\_\_\_

Resources for emotional support?

Check all that apply:  Spouse  Family  Friends  Religious/Spiritual  Pets  Other: \_\_\_\_\_

**GYNECOLOGIC HISTORY (for females only)**

**MENSTRUAL HISTORY**

Age at first period: \_\_\_\_\_ Menses Frequency: \_\_\_\_\_ Length: \_\_\_\_\_ Pain:  Yes  No Clotting:  Yes  No

Has your period ever skipped? \_\_\_\_\_ For how long? \_\_\_\_\_

Last Menstrual Period: \_\_\_\_\_

Does your child use contraception?  Yes  No  Condom  Diaphragm  IUD  Partner Vasectomy

Use of hormonal contraception such as:  Birth Control Pills  Patch  Nuva Ring How long? \_\_\_\_\_

## GI HISTORY

Has your child traveled to foreign countries?  Yes  No Where? \_\_\_\_\_

Wilderness Camping?  Yes  No Where? \_\_\_\_\_

Have you ever had severe:  Gastroenteritis  Diarrhea

## DENTAL HISTORY

Silver Mercury Fillings How many? \_\_\_\_\_

Gold Fillings  Root Canals  Implants  Tooth Pain  Bleeding Gums

Gingivitis  Problems with Chewing

Do you floss regularly?  Yes  No

## PATIENT BIRTH HISTORY

### MOTHER'S PAST PREGNANCIES

Number of: Pregnancies: \_\_\_\_\_ Live births: \_\_\_\_\_ Miscarriages: \_\_\_\_\_

### MOTHER'S PREGNANCY

*Check box if yes and provide description if applicable*

- |  |  |
|--|--|
| <input type="checkbox"/> Difficulty getting pregnant (more than 6 months) _____        | <input type="checkbox"/> Group B strep infection _____                   |
| <input type="checkbox"/> Infertility drugs used Specify: _____                         | <input type="checkbox"/> Have c-section because of _____                 |
| <input type="checkbox"/> In vitro fertilization _____                                  | <input type="checkbox"/> Use induction for labor (such as Pitocin) _____ |
| <input type="checkbox"/> Drink alcohol _____   | <input type="checkbox"/> Have anesthesia, if so list type _____          |
| <input type="checkbox"/> Drink coffee _____  | <input type="checkbox"/> Use oxygen during labor _____                   |
| <input type="checkbox"/> Smoke tobacco _____   | <input type="checkbox"/> Have an x-ray _____                             |
| <input type="checkbox"/> Take Progesterone _____                                       | <input type="checkbox"/> Have Rhogam, if so how many shots _____         |
| <input type="checkbox"/> Take prenatal vitamins _____                                  | How many when pregnant? _____  |
| <input type="checkbox"/> Take antibiotics <input type="checkbox"/> During Labor? _____ | <input type="checkbox"/> Gestational Diabetes _____                      |
| <input type="checkbox"/> Take other drugs Specify: _____                               | <input type="checkbox"/> High blood pressure (pre-eclampsia) _____       |
| <input type="checkbox"/> Excessive vomiting, nausea (more than 3 weeks) _____          | <input type="checkbox"/> High blood pressure/toxemia _____               |
| <input type="checkbox"/> Have a viral infection _____                                  | <input type="checkbox"/> Have chemical exposure _____                    |
| <input type="checkbox"/> Have a yeast infection _____                                  | <input type="checkbox"/> Father have chemical exposure _____             |
| <input type="checkbox"/> Have amalgam fillings put in teeth _____                      | <input type="checkbox"/> Move to a newly built house _____               |
| <input type="checkbox"/> Have amalgam fillings removed from teeth _____                | <input type="checkbox"/> House painted indoors _____                     |
| <input type="checkbox"/> Number of fillings in teeth when pregnant _____               | <input type="checkbox"/> House painted outdoors _____                    |
| <input type="checkbox"/> Have bleeding? If so which months? _____                      | <input type="checkbox"/> House exterminated for insects _____            |
| <input type="checkbox"/> Have birth problems _____                                     |  |

### PREGNANCY

Total weight gain during pregnancy: \_\_\_\_\_ lb Total weight loss during pregnancy: \_\_\_\_\_ lb

Please describe diet during pregnancy: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please describe labor: \_\_\_\_\_  
\_\_\_\_\_

## PATIENT BIRTH HISTORY (CONTINUED)

### PERINATAL

Pregnancy duration: *(Please indicate at what week was your baby born)*

24  25  26  27  28  29  30  31  32  33  34  35  
 36  37  38  39  40 (full term)  41  42  43  44 Weeks

Very active before birth?  Yes  No

Hospital/Birthing Center?  Yes  No

Needed Newborn Special Care?  Yes  No

Appeared healthy?  Yes  No

Easily consoled during first month?  Yes  No

Antibiotics first month?  Yes  No

Experienced no complications first month of life?  Yes  No

### BIRTH WEIGHT AND APGAR

Weight at birth: \_\_\_\_\_ lbs    Apgar score at 1 minute: \_\_\_\_\_    Apgar score at 5 minutes: \_\_\_\_\_

### EARLY CHILDHOOD ILLNESSES

Number of earaches in the first two years: \_\_\_\_\_

Number of other infections in the first two years: \_\_\_\_\_

Number of times you had antibiotics in the first two years of life: \_\_\_\_\_

Number of courses of prophylactic antibiotics in first 2 years of life: \_\_\_\_\_

First antibiotic at \_\_\_\_\_ months.

First illness at \_\_\_\_\_ months.

### DESCRIPTION OF DEVELOPMENTAL PROBLEMS

If your child has developmental problems, at what age did they occur?

0-1 months  2-6 months  7-15 months  16-24 months  After 24 months

Is this impression shared among parents and others caring for the child?  Yes  No

Does this impression, as to the timing of onset, differ among parents and others caring for the child?  Yes  No

Is the impression, as to the timing of onset, weak?  Yes  No

Or is the impression strong?  Yes  No

### DEVELOPMENTAL HISTORY

*Please indicate the approximate age in months for the following milestones: (example: walking 14 months):*

Sitting up \_\_\_\_\_ months  Never

Crawl \_\_\_\_\_ months  Never

Pulled to stand \_\_\_\_\_ months  Never

Potty trained \_\_\_\_\_ months  Never

Walked alone \_\_\_\_\_ months  Never

Dry at night \_\_\_\_\_ months  Never

First words ("mamma", "dada", etc.) \_\_\_\_\_ months  Never

Spoke clearly \_\_\_\_\_ months  Never

Lost language \_\_\_\_\_ months  Never

Lost eye contact \_\_\_\_\_ months  Never







## FAMILY HISTORY

*Check family members that apply*

|   | Mother | Father | Brother(s) | Sister(s) | Children | Maternal Grandmother | Maternal Grandfather | Paternal Grandmother | Paternal Grandfather | Aunts | Uncles | Other |
|---|--------|--------|------------|-----------|----------|----------------------|----------------------|----------------------|----------------------|-------|--------|-------|
| Age (if still alive)  |        |        |            |           |          |                      |                      |                      |                      |       |        |       |
| Age at death (if deceased)  |        |        |            |           |          |                      |                      |                      |                      |       |        |       |
| Cancers   |        |        |            |           |          |                      |                      |                      |                      |       |        |       |
| Colon Cancer  |        |        |            |           |          |                      |                      |                      |                      |       |        |       |
| Breast or Ovarian Cancer  |        |        |            |           |          |                      |                      |                      |                      |       |        |       |
| Heart Disease   |        |        |            |           |          |                      |                      |                      |                      |       |        |       |
| Hypertension  |        |        |            |           |          |                      |                      |                      |                      |       |        |       |
| Obesity   |        |        |            |           |          |                      |                      |                      |                      |       |        |       |
| Diabetes  |        |        |            |           |          |                      |                      |                      |                      |       |        |       |
| Stroke  |        |        |            |           |          |                      |                      |                      |                      |       |        |       |
| Inflammatory Arthritis<br>(Rheumatoid, Psoriatic, Ankylosing Spondylitis) |        |        |            |           |          |                      |                      |                      |                      |       |        |       |
| Inflammatory Bowel Disease  |        |        |            |           |          |                      |                      |                      |                      |       |        |       |
| Multiple Sclerosis  |        |        |            |           |          |                      |                      |                      |                      |       |        |       |
| Auto Immune Diseases (such as Lupus)                                      |        |        |            |           |          |                      |                      |                      |                      |       |        |       |
| Irritable Bowel Syndrome  |        |        |            |           |          |                      |                      |                      |                      |       |        |       |
| Celiac Disease  |        |        |            |           |          |                      |                      |                      |                      |       |        |       |
| Asthma  |        |        |            |           |          |                      |                      |                      |                      |       |        |       |
| Eczema / Psoriasis  |        |        |            |           |          |                      |                      |                      |                      |       |        |       |
| Food Allergies, Sensitivities or Intolerances                             |        |        |            |           |          |                      |                      |                      |                      |       |        |       |
| Environmental Sensitivities   |        |        |            |           |          |                      |                      |                      |                      |       |        |       |
| Dementia  |        |        |            |           |          |                      |                      |                      |                      |       |        |       |
| Parkinson's   |        |        |            |           |          |                      |                      |                      |                      |       |        |       |
| ALS or other Motor Neuron Diseases  |        |        |            |           |          |                      |                      |                      |                      |       |        |       |
| Genetic Disorders   |        |        |            |           |          |                      |                      |                      |                      |       |        |       |
| Substance Abuse (such as alcoholism)                                      |        |        |            |           |          |                      |                      |                      |                      |       |        |       |
| Psychiatric Disorders   |        |        |            |           |          |                      |                      |                      |                      |       |        |       |
| Depression  |        |        |            |           |          |                      |                      |                      |                      |       |        |       |
| Schizophrenia   |        |        |            |           |          |                      |                      |                      |                      |       |        |       |
| ADHD  |        |        |            |           |          |                      |                      |                      |                      |       |        |       |
| Autism  |        |        |            |           |          |                      |                      |                      |                      |       |        |       |
| Bipolar Disease   |        |        |            |           |          |                      |                      |                      |                      |       |        |       |

## NUTRITION HISTORY

Has your child ever had a nutrition consultation?  Yes  No

Have you made any changes in your child's diet because of health problems?  Yes  No Describe \_\_\_\_\_

Does your child follow a special diet or nutritional program?  Yes  No

Check all that apply:

Yeast Free  Feingold  Weight Management  Diabetic  Dairy Free  Wheat Free  Ketogenic  
 Specific Carbohydrate  Gluten Free/Casein Free  Gluten Restricted  Vegetarian  Vegan  Low Oxalate  
Food Allergy (Peanuts, Eggs, etc.): \_\_\_\_\_

Height (feet/inches) \_\_\_\_\_

Current Weight \_\_\_\_\_

Longest Weight Fluctuations  Yes  No

Does your child avoid any particular foods?  Yes  No If yes, types and reason: \_\_\_\_\_

If your child could eat only a few foods daily, what would they be? \_\_\_\_\_

Who does the shopping in your household? \_\_\_\_\_

Who does the cooking in your household? \_\_\_\_\_

How many meals does your child eat out per week?  0-1  1-3  3-5  >5 meals per week

Check all the factors that apply to your child's current lifestyle and eating habits:

- |   |   |
|---|---|
| <input type="checkbox"/> Fast eater                             | <input type="checkbox"/> Most family meals together   |
| <input type="checkbox"/> Erratic eating pattern                 | <input type="checkbox"/> Use food as a bribe or reward  |
| <input type="checkbox"/> Eat too much                           | <input type="checkbox"/> Erratic mealtimes  |
| <input type="checkbox"/> Dislike healthy food                   | <input type="checkbox"/> Most meals eaten at the table  |
| <input type="checkbox"/> Time constraints                       | <input type="checkbox"/> High juice intake  |
| <input type="checkbox"/> Eat more than 50% meals away from home | <input type="checkbox"/> Low fruit/vegetable intake   |
| <input type="checkbox"/> Poor snack choices                     | <input type="checkbox"/> High sugar/sweet intake  |
| <input type="checkbox"/> Sensory issues with food               | <input type="checkbox"/> Drinks soda or diet soda   |
| <input type="checkbox"/> Picky eater                            | <input type="checkbox"/> Cow's Milk 1 2 3+  |
| <input type="checkbox"/> Limited variety of foods <5/day        | <input type="checkbox"/> Caffeine intake  |
| <input type="checkbox"/> Prefers cold food                      | <input type="checkbox"/> TV or videos with meals  |
| <input type="checkbox"/> Prefers hot food                       | <input type="checkbox"/> Challenges with food served outside the home<br>(Ex. childcare, friend's home) |
| <input type="checkbox"/> Every meal is a struggle               |   |

### BREASTFED HISTORY

Breastfed?  Yes  No How long? \_\_\_\_\_ Problems latching on?  Yes  No

Sucking quality?  Very Good  Good  Poor Exclusively breastfed for \_\_\_\_\_ months

### BOTTLE FED HISTORY

Bottle fed?  Yes  No Type of formula:  Soy  Cow's Milk  Low Allergy

Introduction of cow's milk at \_\_\_\_\_ months. Introduction of solid foods at \_\_\_\_\_ months.

First foods introduced at \_\_\_\_\_ months. Introduction of wheat or other grain at \_\_\_\_\_ months.

Choke/Gas/Vomit on milk?  Yes  No Refused to chew solids?  Yes  No

List mother's known food allergies or sensitivities: \_\_\_\_\_

Please describe any other eating concerns that you have regarding your child: \_\_\_\_\_

## ACTIVITY

List type and amount of activity daily.

| Type | Amount Daily |
|------|--------------|
|      |              |
|      |              |
|      |              |
|      |              |
|      |              |
|      |              |
|      |              |

How much time does your child spend watching tv? \_\_\_\_\_

How much time does your child spend on the computer or playing video games? \_\_\_\_\_

## ENVIRONMENTAL HISTORY

Please check appropriate box

| PAST                     | CURRENT                  | EXPOSURES                           |
|--------------------------|--------------------------|-------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Mold in bathroom                    |
| <input type="checkbox"/> | <input type="checkbox"/> | Damp cellar                         |
| <input type="checkbox"/> | <input type="checkbox"/> | Pest extermination - Inside         |
| <input type="checkbox"/> | <input type="checkbox"/> | Pest extermination - Outside        |
| <input type="checkbox"/> | <input type="checkbox"/> | Forced hot air heat                 |
| <input type="checkbox"/> | <input type="checkbox"/> | Had water in basement               |
| <input type="checkbox"/> | <input type="checkbox"/> | Mold visible on exterior of house   |
| <input type="checkbox"/> | <input type="checkbox"/> | Heavily wooded or damp surroundings |

|                          |                          |  |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Mold in cellar, crawl space, or basement |
| <input type="checkbox"/> | <input type="checkbox"/> | Moldy, musty school/daycare              |
| <input type="checkbox"/> | <input type="checkbox"/> | Tobacco smoke                            |
| <input type="checkbox"/> | <input type="checkbox"/> | Well water                               |
| <input type="checkbox"/> | <input type="checkbox"/> | Carpet in bedroom                        |
| <input type="checkbox"/> | <input type="checkbox"/> | Carpet in most parts of house            |
| <input type="checkbox"/> | <input type="checkbox"/> | Feather or down bedding                  |

## SOME THINGS ABOUT YOUR PARENTS

When were your parents married: \_\_\_\_\_ If separated, when: \_\_\_\_\_

If divorced, when: \_\_\_\_\_ If remarried, when: \_\_\_\_\_

Custody arrangements: \_\_\_\_\_

### MOTHER - PERSONAL

Age at your birth \_\_\_\_\_

Education \_\_\_\_\_

Ethnicity \_\_\_\_\_

Blood type \_\_\_\_\_

### FATHER - PERSONAL

Age at your birth \_\_\_\_\_

Education \_\_\_\_\_

Ethnicity \_\_\_\_\_

Blood type \_\_\_\_\_

## SYMPTOM REVIEW

Please check all current symptoms occurring or present in the past 6 months.

### STRENGTHS

- Especially attractive
- Accepts new clothes
- Cuddly
- Physically coordinated
- Happy
- Pleasant/easy to care for
- Sensitive/affectionate
- Wants to be liked
- Responsible
- Draws accurate pictures
- Sensitive to peoples feelings
- OK if parents leave
- Answers parent
- Follows instructions
- Pronounces words well
- Unusual memory
- Perfect musical pitch
- Good with math
- Good with computer
- Good with fine work
- Good throwing and catching
- Good climbing
- Strong desire to do things
- Swimming
- Bold, free of fear
- Likes to be held
- Likes to be swaddled

### SLEEP

- Sleeps in own bed
- Sleeps with parent(s)
- Awakens screaming/crying
- Awakes at night
- Difficulty falling asleep
- Early waking
- Insomnia
- Sleeps less than normal
- Daytime sleepiness
- Jerks during sleep
- Nightmares
- Sleeps more than normal

### PHYSICAL

- Looks sick
- Glazed look
- Overweight
- Underweight
- Pupils unusually large

- Unusually long eye lashes
- Pupils unusually small
- Dark circles under eyes
- Red lips
- Red fingers
- Red toes
- Webbed toes
- Red ears
- Double jointed
- High arched palate
- Lymph nodes enlarged neck
- Head warm
- Head sweats
- Night sweats
- Abnormal fatigue
- Failure to thrive
- Cold all over
- Cold hands and feet
- Cold intolerance
- Hands/feet - very sweaty
- Head very hot/sweaty
- Night sweats
- Perspiration - odd odor

### SKIN

- Paleness, severe
- Fungus / fingernails
- Fungus / toenails
- Dandruff
- Chicken skin
- Oily skin
- Patchy dullness
- Seborrhea on face
- Thick calluses
- Athletes foot
- Feet - stinky
- Diaper rash
- Odd body odor
- Strong body odor
- Acne
- Dark circle under eyes
- Ears get red
- Eczema
- Flushing
- Red face
- Sensitive to insect bites
- Stretch marks
- Blotchy skin
- Bugs love to bite you

- Cradle cap
- Dry hair
- Dry scalp
- Hair unmanageable
- Bites nails
- Nails brittle
- Nails frayed
- Nails pitted
- Nails soft
- Skin pale
- Dark birth mark(s)
- Easy bruising
- Inability to tan
- Light birth mark(s)
- Ragged cuticles
- Thickening fingernails
- Thickening toenails
- Vitiligo
- White spots or lines in nails
- Dry skin in general
- Feet cracking
- Feet peeling
- Hands cracking
- Hands peeling
- Lower legs dry
- Skin lackluster
- Itchy skin in general
- Itchy scalp
- Itchy ear canals
- Itchy eyes
- Itchy nose
- Itchy roof of mouth
- Itchy arms
- Itchy hands
- Itchy legs
- Itchy feet
- Itchy anus
- Itchy penis
- Itchy vagina

### DIGESTIVE

- Breath bad
- Increased salivation
- Drooling
- Cracking lip corners
- Cold sores on lips, face
- Geographic tongue (map-like)
- Sore tongue
- Tongue coated



- Canker sores in mouth
- Gums bleed
- Teeth grinding
- Tooth cavities
- Tooth with amalgam fillings
- Mouth thrush (yeast infection)
- Sore throat
- Fecal belching
- Burping
- Nausea
- Reflux
- Spitting up
- Vomiting
- Abdominal bloating
- Lower abdominal bloating
- Colic
- Abdomen distended
- Abdominal pain
- Intestinal parasites
- Pinworms
- Crampy pain with pooping
- Constipation
- Diarrhea
- Farting - regular
- Farting - stinky
- Anal fissures
- Red ring around anus
- Stools bulky
- Stools light color
- Stools very stinky
- Stools with blood
- Stools with mucus
- Stools with undigested food
- Flatulence
- Stool odor foul
- Stool odor yeasty
- Stools pale
- Stools slimy
- Stools watery

### **EATING**

- Poor appetite
- Thirst
- Extreme water drinking
- Bingeing
- Bread craving
- Craving for carbohydrates
- Craving for juice
- Craving for salt
- Diet soda craving
- Pica (eating non-edibles)
- Abnormal food cravings
- Carbohydrate intolerance

- Starch/disaccharide intol.
- Sugar intolerance
- Salicylate intolerance
- Oxalate intolerance
- Phenolics intolerance
- MSG intolerance
- Food coloring intolerance
- Gluten Intolerance
- Casein intolerance
- Specific food(s) intolerance
- Lactose intolerance
- Behavior worse with food
- Behavior better when fasting

### **BEHAVIOR**

- Behavior purposeless
- Unusual play
- Uses adults hand for activity
- Aloof, indifferent, remote
- Doesn't do for self
- Extremely cautious
- Hides skill/knowledge
- Lacks initiative
- Lost in thought, unreachable
- No purpose to play
- Poor focus, attention
- Sits long time staring
- Uninterested in live pet
- Watches television long time
- Won't attempt/can't do
- Poor sharing
- Rejects help
- Curious/gets into things
- Erratic
- Unable to predict actions
- Destructive
- Hyperactive
- Constant movement
- Melt downs
- Tantrums
- Self mutilation
- Runs away
- Jumps when pleased
- Whirls self like a top
- Climbs to high places
- Insists on what wanted
- Tries to control others
- Head banging
- Falls, gets hurt running climbing
- Does opposite/asked
- Teases others
- Silly
- Shrieks

- Holds hands in strange pose
- Spends time w/ pointless task
- Stares at own hands
- Toe walking
- Arched back with bright lights
- Imitates others
- Finger flicking
- Flaps hands
- Licking
- Likes spinning objects
- Likes to flick finger in eye
- Likes to spin things
- Rhythmic rocking
- Slapping books
- Tooth tapping
- Visual stims
- Wiggle finger front of face
- Wiggle finger side of face
- Bites or chews fingers
- Bites wrist or back of hands
- Chews on things

### **MOOD**

- Apathy
- Blank look
- Depression
- Detached
- Disinterested
- Eye contact poor
- Isolates
- Negative
- Fright without cause
- Always frightened
- Anguish
- Discontented
- Does not want to be touched
- Inconsolable crying
- Irritable
- Looks like in pain
- Moaning, groaning
- Phobias
- Restless
- Severe mood swings
- Unhappy
- Agitated
- Anxious

### **SENSORY**

- Bothered by certain sounds
- Covers ears with sounds
- Ear pain
- Ear ringing
- Hearing acute

- Hearing loss
- Likes certain sounds
- Sensitive to loud noise
- Sounds seem painful
- Tinnitus
- Acute sense of smell
- Examines by smell
- Intensely aware of odors
- Blinking
- Bothered by bright lights
- Distorted vision
- Conjunctivitis
- Eye crusting
- Eye problem
- Lid margin redness
- Examines by sight
- Fails to blink at bright light
- Likes fans
- Likes flickering lights
- Looks out of corner of eye
- Poor vision
- Puts eye to bright light or sun
- Strabismus (crossed eye)
- Fearful of harmless object
- Fearful of unusual events
- Unaware of danger
- Unaware of peoples' feelings
- Unaware of self as person
- Upset if things change
- Upset of things aren't right
- Adopts complicated rituals
- Car, truck, train obsession
- Collects particular things
- Draws only certain things
- Fixated on one topic
- Lines objects precisely
- Repeats old phrases
- Repetitive play/objects
- Finger tip squeezing
- Hates wearing shoes
- Insensitive to pain
- Likes head burrowed
- Likes head pressed hard
- Likes head rubbed
- Likes head under blanket
- Likes to be held upside down
- Likes to be swung in the air
- Very insensitive to pain
- Very sensitive to pain

#### NEUROMUSCULAR

- Clumsiness
- Coordination
- Fine motor poor

- Gross motor poor
- Holds bizarre posture
- Hyperactivity
- Physically awkward
- Rocking
- Stiffens body when held
- Calf cramps
- Foot cramps
- Muscle pain
- Muscle tone tense
- Muscle twitches
- Fist clenching
- Jaw clenching
- Poor muscle tone/limp
- Tics
- Muscle tone low trunk
- Muscle weakness, atrophy
- Muscle tone low all over
- Tremors
- Cognitive delays
- Memory poor
- Poor attention, focus
- Slow and sluggish
- Expressive language delay

#### SPEECH

- Never spoke
- Occas. words when excited
- Expressive language poor
- No answers simple questions
- Points to objects/can't name
- Speech apraxia
- Does not ask questions
- Babbling
- Asks using "you" not "I"
- Answers by repeating question
- Receptive language poor
- Says "I"
- Says "no"
- Says "yes"
- Lost language @ 12-24 months
- Lost language after 24 months
- Scripting
- Stuttering
- Talks to self
- Poor auditory processing
- Unusual sound of cry
- Uses one word for another
- Rigid behaviors
- Poor confidence
- Timid
- Corrects imperfections
- Tidy

#### RESPIRATORY

- Pneumonia
- Bad odor in nose
- Breath holding
- Bronchitis
- Congestion chg. season
- Congestion in the fall
- Congestion in the spring
- Congestion in the summer
- Congestion in the winter
- Cough
- Post nasal drip
- Runny nose
- Sighing
- Sinus fullness
- Wheezing
- Yawning

#### REPRODUCTIVE

- Girls: Early first period
- Boys: Large testicles
- Early breast development
- Early pubic hair
- Girls: vaginal odor

#### URINARY

- Frequent urination
- Bed wetting after age 4
- Odd urinary odor
- Urinary hesitancy
- Urinary tract infections
- Urinary urgency
- Dry at night
- Seizures - focal
- Seizures - generalized
- Seizures - grand mal
- Seizures - petit mal
- Unusually fast heart beat
- Heart murmur
- Headaches
- Joint pains
- Leg pains
- Muscle pains

## READINESS ASSESSMENT

Rate on a scale of 5 (very willing) to 1 (not willing):

In order to improve your child’s health, how willing is the patient in:

- Significantly modify diet . . . . .  5  4  3  2  1
- Take several nutritional supplements each day . . . . .  5  4  3  2  1
- Keeping a record of everything eaten each day . . . . .  5  4  3  2  1
- Modify lifestyle (e.g., school/work demands, sleep habits) . . . . .  5  4  3  2  1
- Practicing a relaxation technique . . . . .  5  4  3  2  1
- Engaging in regular exercise . . . . .  5  4  3  2  1
- Having periodic lab tests to assess progress . . . . .  5  4  3  2  1

Comments \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Rate on a scale of 5 (very confident) to 1 (not confident at all):

How confident are you of your ability to organize and follow through on the above health related activities? -  5  4  3  2  1

If you are not confident of your ability, what aspects of yourself or your life lead you to question your capacity to fully engage in the above activities? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Rate on a scale of 5 (very supportive) to 1 (very unsupportive):

At the present time, how supportive do you think the people in your household will be to your implementing the above changes? -  5  4  3  2  1

Comments \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Rate on a scale of 5 (very frequent contact) to 1 (very infrequent contact):

How much on-going support and contact (e.g., telephone consults, e-mail correspondence) from our professional staff would be helpful to you as you implement your personal health program? -  5  4  3  2  1

Comments \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_







# MSQ - MEDICAL SYMPTOM/TOXICITY QUESTIONNAIRE

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

The Toxicity and Symptom Screening Questionnaire identifies symptoms that help to identify the underlying causes of illness, and helps you track your progress over time. Rate each of the following symptoms based upon your health profile for the past 30 days. If you are completing this after your first time, then record your symptoms for the last 48 hours ONLY.

## POINT SCALE

0 = Never or almost never have the symptom  
1 = Occasionally have it, effect is not severe

2 = Occasionally have, effect is severe  
3 = Frequently have it, effect is not severe  
4 = Frequently have it, effect is severe

### DIGESTIVE TRACT

\_\_\_ Nausea or vomiting  
\_\_\_ Diarrhea  
\_\_\_ Constipation  
\_\_\_ Bloating feeling  
\_\_\_ Belching or passing gas  
\_\_\_ Heartburn  
\_\_\_ Intestinal/Stomach pain

Total \_\_\_\_\_

### EARS

\_\_\_ Itchy ears  
\_\_\_ Earaches, ear infections  
\_\_\_ Drainage from ear  
\_\_\_ Ringing in ears, hearing loss

Total \_\_\_\_\_

### EMOTIONS

\_\_\_ Mood swings  
\_\_\_ Anxiety, fear or nervousness  
\_\_\_ Anger, irritability or aggressiveness  
\_\_\_ Depression

Total \_\_\_\_\_

### ENERGY/ACTIVITY

\_\_\_ Fatigue, sluggishness  
\_\_\_ Apathy, lethargy  
\_\_\_ Hyperactivity  
\_\_\_ Restlessness

Total \_\_\_\_\_

### EYES

\_\_\_ Watery or itchy eyes  
\_\_\_ Swollen, reddened or sticky eyelids  
\_\_\_ Bags or dark circles under eyes  
\_\_\_ Blurred or tunnel vision (does not include near or far-sightedness)

Total \_\_\_\_\_

### HEAD

\_\_\_ Headaches  
\_\_\_ Faintness  
\_\_\_ Dizziness  
\_\_\_ Insomnia

Total \_\_\_\_\_

### HEART

\_\_\_ Irregular or skipped heartbeat  
\_\_\_ Rapid or pounding heartbeat  
\_\_\_ Chest pain

Total \_\_\_\_\_

### JOINTS/MUSCLES

\_\_\_ Pain or aches in joints  
\_\_\_ Arthritis  
\_\_\_ Stiffness or limitation of movement  
\_\_\_ Pain or aches in muscles  
\_\_\_ Feeling of weakness or tiredness

Total \_\_\_\_\_

### LUNGS

\_\_\_ Chest congestion  
\_\_\_ Asthma, bronchitis  
\_\_\_ Shortness of breath  
\_\_\_ Difficult breathing

Total \_\_\_\_\_

### MIND

\_\_\_ Poor memory  
\_\_\_ Confusion, poor comprehension  
\_\_\_ Poor concentration  
\_\_\_ Poor physical coordination  
\_\_\_ Difficulty in making decisions  
\_\_\_ Stuttering or stammering  
\_\_\_ Slurred speech  
\_\_\_ Learning disabilities

Total \_\_\_\_\_

### MOUTH/THROAT

\_\_\_ Chronic coughing  
\_\_\_ Gagging, frequent need to clear throat  
\_\_\_ Sore throat, hoarseness, loss of voice  
\_\_\_ Swollen/dischored tongue, gum, lips  
\_\_\_ Canker sores

Total \_\_\_\_\_

### NOSE

\_\_\_ Stuffy nose  
\_\_\_ Sinus problems  
\_\_\_ Hay fever  
\_\_\_ Sneezing attacks  
\_\_\_ Excessive mucus formation

Total \_\_\_\_\_

### SKIN

\_\_\_ Acne  
\_\_\_ Hives, rashes or dry skin  
\_\_\_ Hair loss  
\_\_\_ Flushing or hot flushes  
\_\_\_ Excessive sweating

Total \_\_\_\_\_

### WEIGHT

\_\_\_ Binge eating/drinking  
\_\_\_ Craving certain foods  
\_\_\_ Excessive weight  
\_\_\_ Compulsive eating  
\_\_\_ Water retention  
\_\_\_ Underweight

Total \_\_\_\_\_

### OTHER

\_\_\_ Frequent illness  
\_\_\_ Frequent or urgent urination  
\_\_\_ Genital itch or discharge

Total \_\_\_\_\_

**GRAND TOTAL** \_\_\_\_\_

## KEY TO QUESTIONNAIRE

Add individual scores and total each group. Add each group score and give a grand total.

• Optimal is less than 10 • Mild Toxicity: 10-50 • Moderate Toxicity: 50-100 • Severe Toxicity: over 100