Dear Caregiver,

Thank you for taking time to fill out this questionnaire. It is extensive, but history plays a vital role in Functional Medicine so that your time and accuracy in filling out this document will allow us to best serve your child, you and your family. As well, the more detail that is on the form prior to our visit, the more time we will have to review the problems and their potential solutions. Dates of occurrence/onset are very useful to understand the problem.

It is NOT designed to be completed in one sitting, but rather as many as three reviews of the information is suggested to optimize the details. For areas that do not apply, please put “N/A” rather than leave them blank. If there is something that you do not know or are unclear about, please let me know by placing a question mark by that item.

Your attention to detail in the 5 day diet, behavior and symptom log will be invaluable. Here too, the more information about products (the brand or special characteristics such as gluten or dairy free if applicable) will help me immensely to evaluate what has been consumed.

AFTER you have returned the document you will be given an appointment. This will allow us to have adequate time to evaluate the history, plan the interventions and tests to make our time together more productive.

If you have any questions, please call the office to clarify.

I look forward to working together in this journey.

Sincerely,

David A, Katz, DO FAAP IFMCP
Pediatric Medical Questionnaire

GENERAL INFORMATION
Name: ________________________________________________________________________________
First    Middle    Last     (Preferred if different)
Preferred Name: _________________________________________________________________________
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: __________________________
Primary Address (person completing this questionnaire)
Number, Street ____________________________ Apt. No. ____________
City ____________________________ State ____________________________ Zip ____________
Alternate Address:
Number, Street ____________________________ Apt. No. ____________
City ____________________________ State ____________________________ Zip ____________
Home Phone 1: ____________________________ Home Phone 2: ____________________________
Parent’s Work Phone: ____________________________ Parent’s Cell Phone: ____________________________
Fax: ____________________________ Email: ____________________________
Emergency Contact:
Name ____________________________ Phone Number ____________________________
Address ____________________________ Apt. No. ____________________________
City ____________________________ State ____________________________ Zip ____________
Physician:
Name ____________________________ Phone Number ____________________________
Fax ____________________________
Referred by ○ Book ○ Website ○ Media ○ Friend / Family Member ○ Other
Insurance: ○ North Carolina BCBS ○ OTHER BCBS ○ AETNA ○ CIGNA ○ UNITED HEALTHCARE
○ Other
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:

<table>
<thead>
<tr>
<th>Describe Problem</th>
<th>Mild</th>
<th>Moderate</th>
<th>Severe</th>
<th>Prior Treatment/Approach</th>
<th>Excellent</th>
<th>Good</th>
<th>Fair</th>
</tr>
</thead>
<tbody>
<tr>
<td>Example: Difficulty Maintaining Attention</td>
<td>X</td>
<td>Elimination Diet</td>
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</table>

Success
### Pediatric Medical Questionnaire

#### Medical History

Diseases/Diagnosis/Conditions (*Check appropriate box and provide date of onset, resolution*)

**GASTROINTESTINAL**

<table>
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**CARDIOVASCULAR**

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**METABOLIC/ENDOCRINE**

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**CANCER**

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**GENITAL AND URINARY SYSTEMS**

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**MUSCULOSKELETAL/PAIN**

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**INFLAMMATORY/AUTOIMMUNE**

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**RESPIRATORY DISEASES**

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</table>
**Pediatric Medical Questionnaire**

### SKIN DISEASES

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<td></td>
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<td>Acne</td>
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### NEUROLOGIC/MOOD

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<td>Bipolar Disorder</td>
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<td>Schizophrenia</td>
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<td></td>
<td></td>
<td>Headaches</td>
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<td>Migraines</td>
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<td>ADD/ADHD</td>
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<td>Sensory Integrative Disorder</td>
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<td>Mild Cognitive Impairment</td>
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<td>Other Neurological Problems</td>
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### PREVIOUS EVALUATIONS

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<td>Full Physical Exam</td>
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<tr>
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<td>Psychological Evaluations</td>
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<td>Wechsler Preschool &amp; Primary Scale of Intelligence</td>
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<td>Speech and Language Evaluations</td>
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<td>Gastroenterology Evaluations</td>
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<td>Celiac/Gluten testing</td>
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<td>Allergy Evaluation</td>
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<td>Nutritional Evaluation</td>
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<td>Auditory Evaluation</td>
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<td>Vision Evaluation</td>
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### INJURIES

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<td>Back injury</td>
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<td>Head Injury</td>
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<td>Broken Bones</td>
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### SURGERIES

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<td>Appendectomy</td>
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<td>Circumcision</td>
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<td>Adenoids</td>
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<td>Dental Surgery</td>
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<td></td>
<td>Tubes in Ears</td>
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<td>Other</td>
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</table>

### BLOOD TYPE:

- A
- B
- AB
- 0
- Rh+  unknown
Pediatric Medical Questionnaire

HOSPITALIZATIONS  □  None

<table>
<thead>
<tr>
<th>Date</th>
<th>Reason</th>
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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
Have 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
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  trouble staying asleep?  ○Yes  ○No
Does your child feel rested upon awakening?  ○Yes  ○No
Does your child snore?  ○Yes  ○No

ROLES/RELATIONSHIPS
List Family Members:

<table>
<thead>
<tr>
<th>Family Member and Relationship</th>
<th>Age</th>
<th>Gender</th>
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<tbody>
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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: __________
Pediatric Medical Questionnaire

GYNECOLOGIC HISTORY (FOR WOMEN or Young adult female patients 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: ___________
Use of hormonal contraception such as: □Birth Control Pills □Patch □Nuva Ring  How long? ______
Do you use contraception? ○Yes ○No □Condom □Diaphragm □IUD □Partner vasectomy

GI HISTORY
Has your child traveled to foreign countries? ○Yes ○No Where? ________________________________
Wilderness Camping? ○Yes ○No Where? _________________________________________________
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
□ Difficulty getting pregnant (more than 6 months)
□ Infertility drugs used Specify: __________
□ In vitro fertilization  □Drink alcohol  □Smoke tobacco
□ Drink coffee  □Take Progesterone
□ Take prenatal vitamins  □Take antibiotics □During Labor? __________
□ Take other drugs Specify: __________
□Excessive vomiting, nausea (more than 3 weeks)
□ Have a viral infection
□ Have a yeast infection
□ Have amalgam fillings put in teeth
□ Have amalgam fillings removed from teeth

□ Number of fillings in teeth when pregnant?
□ Have bleeding (which months?) __________
□ Have birth problems
□ Group B strep infection
□ Have c-section because of __________
□ Use induction for labor (such as Pitocin) __
□ Have anesthesia -what was used? __________
□ Use oxygen during labor
□ Have an x-ray
□ Have Rhogam, if so how many shots __________
□ How many when pregnant? __________
□ Gestational Diabetes
□ High blood pressure (pre-eclampsia) __________
□ High blood pressure/toxemia
□ Have chemical exposure
□ Father have chemical exposure
□ Move to a newly built house
□ House painted indoors
□ House painted outdoors
□ House exterminated for insects
Pediatric Medical Questionnaire

PREGNANCY

Total weight gain during pregnancy: ________ lb    Total weight loss during pregnancy: ________ lb

Please describe diet during pregnancy: ______________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
________________________________________________________________

Please describe labor: __________________________________________________________
_____________________________________________________________________________________
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_____________________________________________________________________________________
________________________________________________________________

PERINATAL

Pregnancy duration: *circle preceding the week of gestation.*
○ 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 one minute: ________ Apgar score at 5 mins: ________

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  ○ 6-15 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
**Pediatric Medical Questionnaire**

**DEVELOPMENTAL HISTORY**

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

<table>
<thead>
<tr>
<th>Developmental Milestone</th>
<th>Age (months)</th>
<th>Status</th>
<th>Status Description</th>
<th>Age (months)</th>
<th>Status</th>
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<td>○Never</td>
<td></td>
<td></td>
<td>○Never</td>
</tr>
<tr>
<td>Crawl</td>
<td></td>
<td>○Never</td>
<td></td>
<td></td>
<td>○Never</td>
</tr>
<tr>
<td>Pulled to stand</td>
<td></td>
<td>○Never</td>
<td></td>
<td></td>
<td>○Never</td>
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<td>Dry at night</td>
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<td>○Never</td>
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<td>○Never</td>
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**MEDICATIONS**

*Current Medications*

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<th>Dose</th>
<th>Frequency</th>
<th>Start Date (month/year)</th>
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*Previous Medications: Last 10 years*

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<tr>
<th>Medication</th>
<th>Dose</th>
<th>Frequency</th>
<th>Start Date (month/year)</th>
<th>Reason for Use</th>
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**Nutritional Supplements (Vitamins/Minerals/Herbs/Homeopathy)**

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<tr>
<th>Suppllication and Brand</th>
<th>Dose</th>
<th>Frequency</th>
<th>Start Date (month/year)</th>
<th>Reason for Use</th>
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DAX 70119
Pediatric Medical Questionnaire

Have your medications or supplements ever caused you unusual side effects or problems?  ○Yes ○No
Describe: __________________________________________________________________________

Have you had prolonged or regular use of NSAIDS (Advil, Aleve, Motrin, Aspirin etc.)?  ○Yes ○No
Have you had prolonged or regular use of Tylenol?  ○Yes ○No
Have you had prolonged or regular use of Acid Blocking Drugs (Tagamet, Zantac, Prilosec, etc.)  ○Yes ○No
Frequent antibiotics > 3 times/year  ○Yes ○No
Long term antibiotics  ○Yes ○No
Use of steroids (prednisone, nasal/asthma allergy inhalers) in the past  ○Yes ○No
Use of oral contraceptives  ○Yes ○No
## Pediatric Medical Questionnaire

### FAMILY HISTORY

Check family members that apply
Specify individual if possible

<table>
<thead>
<tr>
<th>Family Member</th>
<th>Mother</th>
<th>Father</th>
<th>Brother(s)</th>
<th>Sister(s)</th>
<th>Children</th>
<th>Maternal Grandparents</th>
<th>Paternal Grandparents</th>
<th>Aunts</th>
<th>Uncles</th>
<th>Other</th>
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<td>Age (if still alive)</td>
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<td>Breast or Ovarian Cancer</td>
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<td>Inflammatory Arthritis (rheumatoid, Psoriatic, Ankylosing Spondylitis)</td>
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<td>Auto Immune Disease (such as Lupus)</td>
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# Pediatric Medical Questionnaire

## NUTRITIONAL 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 (Ex. Peanuts, Eggs, etc.): ________________________________

<table>
<thead>
<tr>
<th>Height (feet/inches)</th>
<th>Current Weight</th>
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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 current lifestyle and eating habits:

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

## BREASTFED HISTORY

Breastfed?  ☐ Yes  ☐ No  How long? ________ Problems latching on?  ☐ Yes  ☐ No

Sucking quality?  ☐ Very Good  ☐ Good  ☐ Poor  Exclusively breastfed for ________ months

## BOTTLEFED 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: ________________________________
Pediatric Medical Questionnaire

ACTIVITY
List type and amount of activity daily:

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<tr>
<th>Type</th>
<th>Amount Daily</th>
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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

EXPOSURES

Past | Current
---|---
☐ | ☐ Mold in bathroom
☐ | ☐ Damp cellar
☐ | ☐ Pest extermination - Inside
☐ | ☐ Pest extermination - Outside
☐ | ☐ Forced hot air heat
☐ | ☐ Had water in basement
☐ | ☐ Mold visible on exterior of house
☐ | ☐ Heavily wooded or damp surroundings

☐ | ☐ Mold in cellar, crawl space, or basement
☐ | ☐ Moldy, musty school/daycare
☐ | ☐ Tobacco smoke
☐ | ☐ Well water
☐ | ☐ Carpet in bedroom
☐ | ☐ Carpet in most parts of house
☐ | ☐ Feather or down bedding

SOME THINGS ABOUT PATIENT’S 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 ____________________
**Pediatric Medical Questionnaire**

**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
- Unusual 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 finger nails
- 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 coated
- Gums bleed
- Teeth grinding
- Tooth cavities
- Tooth with amalgam fillings
- Mouth thrush (yeast infection)
- Sore throat
- Fecal belching
Pediatric Medical Questionnaire

- Burping
- Nausea
- Reflux
- Spitting up
- Vomiting
- Abdominal bloating
- Lower abdominal bloating
- Colic
- Abdomen distended
- Abdominal pain
- Intestinal parasites
- Pinworms
- Crampy pain with pooping
- Constipation
- 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
Pediatric Medical Questionnaire

☐ 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
☐ Fixed 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
☐ Clumsinesness
☐ 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
☐ Unusual fast heart beat
☐ Heart murmur
☐ Headaches
☐ Joint pains
☐ Leg pains
☐ Muscle pains
Pediatric Medical Questionnaire

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 modifying diet -
  - O5  O4  O3  O2  O1
- Taking several nutritional supplements each day -
  - O5  O4  O3  O2  O1
- Keeping a record of everything eaten each day -
  - O5  O4  O3  O2  O1
- Modifying lifestyle (e.g., work demands, sleep habits) -
  - O5  O4  O3  O2  O1
- Practicing a relaxation technique -
  - O5  O4  O3  O2  O1
- Engaging in regular exercise -
  - O5  O4  O3  O2  O1
- Have periodic lab tests to assess progress -
  - O5  O4  O3  O2  O1

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? –

- O5  O4  O3  O2  O1

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?

Comments

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? -

- O5  O4  O3  O2  O1

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 child’s health program? –

- O5  O4  O3  O2  O1

How willing to use an outside source of support such as a certified health coach to help you?

- O5  O4  O3  O2  O1

Comments

DAK 70119

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Pediatric Medical Questionnaire

5-DAY DIET DAIRY INSTRUCTIONS

It is important to keep an accurate record of your child’s usual food and beverage intake as a part of the treatment plan. Please complete this Diet Diary for 5 consecutive days including one weekend day.

- Do not change your child’s eating behavior at this time, as the purpose of this food record is to analyze present eating habits.
- Record information as soon as possible after the food has been consumed.
- Describe the food or beverage as accurately as possible e.g., milk - what kind? (whole, 2%, nonfat); toast - (whole wheat, white, buttered); chicken - (fried, baked, breaded), coffee – (decaffeinated with sugar and ½ & ½).
- Record the approximate amount of each food or beverage consumed using standard measurements such as 8 ounces, 1/2 cup, 1 teaspoon, etc.
- Include any added items. For example: tea with 1 teaspoon honey, potato with 2 teaspoons butter, etc.
- Record all beverages, including water, coffee, tea, sports drinks, sodas/diet sodas, etc.
- Include any additional comments about your child’s eating habits AND BEHAVIORS on this form (ex. craving sweet, skipped meal and why, when the meal was at a restaurant, etc). ALSO, any other things we should know about.
- Please note all bowel movements and their consistency (regular, loose, firm, etc.)

DIET DIARY

Name ____________________________________________ Date _______________________

<table>
<thead>
<tr>
<th>DAY 1</th>
<th>TIME</th>
<th>FOOD/BEV/AMOUNT</th>
<th>COMMENTS</th>
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Bowel Movements (#, form, color) ______________________________________________________
Stress/Mood/Emotions ________________________________________________________________
Other Comments ________________________________________________________________
### Pediatric Medical Questionnaire

#### DAY 2

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- Bowel Movements (#, form, color)
- Stress/Mood/Emotions
- Other Comments
  - Other

#### DAY 3

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- Bowel Movements (#, form, color)
- Stress/Mood/Emotions
- Other Comments
  - Other
# Pediatric Medical Questionnaire

## DAY 4

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Bowel Movements (#, form, color) ____________________________________________
Stress/Mood/Emotions _______________________________________________________
Other Comments _________________________________________________________
Other ___________________________________________________________________

## DAY 5

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</tbody>
</table>

Bowel Movements (#, form, color) ____________________________________________
Stress/Mood/Emotions _______________________________________________________
Other Comments _________________________________________________________
# Pediatric Medical Questionnaire

**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 track your child’s progress over time. Rate each of the following symptoms based upon your child’s health profile for the past 30 days. If you are taking after the first time, record your child’s symptoms for the last 48 hours ONLY.

**POINTS SCALE**

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
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<tbody>
<tr>
<td>0</td>
<td>Never or almost never have the symptom</td>
</tr>
<tr>
<td>1</td>
<td>Occasionally have it, effect is not severe</td>
</tr>
<tr>
<td>2</td>
<td>Occasionally have, effect is severe</td>
</tr>
<tr>
<td>3</td>
<td>Frequently have it, effect is not severe</td>
</tr>
<tr>
<td>4</td>
<td>Frequently have it, effect is severe</td>
</tr>
</tbody>
</table>

**DIGESTIVE TRACT**

- Nausea or vomiting
- Diarrhea
- Constipation
- Bloated feeling
- Belching, or passing gas
- Heartburn
- Intestinal/Stomach pain

**Total**

**EARS**

- Itchy ears Total
- 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**

**MOUTH/THROAT**

- Chronic coughing
- Gagging, frequent need to clear throat
- Sore throat, hoarseness, loss of voice
- Swollen/discolored 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 scores and give a grand total. Optimal is less than 10 • Mild Toxicity: 10-50 • Moderate Toxicity: 50-100 • Severe Toxicity: over 100
# WEEKLY SYMPTOM CHECKLIST FOR CHILDREN

Name______________________________ Date________________________

Rate each of the following symptoms based on your child’s current health profile

**Point Scale**
- 0 - *Never or almost never* has the symptom
- 1 - *Occasionally* has symptoms
- 2 - *Frequently* has symptoms

<table>
<thead>
<tr>
<th>Area</th>
<th>Symptoms</th>
<th>Rating</th>
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</thead>
<tbody>
<tr>
<td>HEAD</td>
<td>Headaches</td>
<td></td>
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<tr>
<td></td>
<td>Difficulty falling asleep</td>
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<tr>
<td></td>
<td>Wakes up during the night</td>
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<td>Total</td>
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<tr>
<td>EYES</td>
<td>Watery or itchy eyes</td>
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</tr>
<tr>
<td></td>
<td>Dark circles under eyes</td>
<td></td>
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<tr>
<td></td>
<td>Bags under eyes</td>
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<tr>
<td></td>
<td>Swollen eyelids</td>
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<td></td>
<td>Total</td>
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<tr>
<td>EARS</td>
<td>Reddening of ears</td>
<td></td>
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<tr>
<td></td>
<td>Itchy ears</td>
<td></td>
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<tr>
<td></td>
<td>Earaches/Ear infections (circle which apply)</td>
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<tr>
<td></td>
<td>Drainage from ear</td>
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<tr>
<td></td>
<td>Hearing loss</td>
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<tr>
<td></td>
<td>Frequent pulling on ears</td>
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<td></td>
<td>Total</td>
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<tr>
<td>NOSE</td>
<td>Runny nose</td>
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<tr>
<td></td>
<td>Stuffy nose</td>
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<tr>
<td></td>
<td>Sneezing</td>
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<tr>
<td></td>
<td>“Allergic Salute” (rubs, itches, wipes nose frequently with hands)</td>
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<tr>
<td></td>
<td>Total</td>
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<tr>
<td>MOUTH/THROAT</td>
<td>Swollen or red lips</td>
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<tr>
<td></td>
<td>Gagging, frequent need to clear throat</td>
<td></td>
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<tr>
<td></td>
<td>Sore throat, hoarseness, loss of voice</td>
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<tr>
<td></td>
<td>Swollen or sore or discolored tongue</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Swollen or sore gums or lips</td>
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<tr>
<td></td>
<td>Canker sores</td>
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<td>Total</td>
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<tr>
<td>SKIN</td>
<td>Easy bruising</td>
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</tr>
<tr>
<td></td>
<td>Hives</td>
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<td></td>
<td>Rash</td>
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<td>Dry or flaky skin</td>
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<tr>
<td></td>
<td>Flushing</td>
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<td>Cold hands or feet</td>
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DAX 70119
<table>
<thead>
<tr>
<th>Category</th>
<th>Symptoms</th>
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<tbody>
<tr>
<td><strong>LUNGS</strong></td>
<td>Eczema</td>
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<td></td>
<td>Sneezing</td>
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<tr>
<td></td>
<td>Difficulty breathing</td>
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<td></td>
<td>Wheezing</td>
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<tr>
<td><strong>DIGESTIVE TRACT</strong></td>
<td>Nausea</td>
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<td>Vomiting</td>
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<td>Diarrhea</td>
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<td>Constipation</td>
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<td>Bloated feeling</td>
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<td></td>
<td>Belching</td>
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<td>Passing gas (flatulence)</td>
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<td></td>
<td>Heartburn</td>
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<td>Tummy ache</td>
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<td></td>
<td>Poor appetite</td>
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<td></td>
<td>Refusal to eat</td>
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<tr>
<td><strong>JOINTS/MUSCLE</strong></td>
<td>Coordination problems</td>
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<td></td>
<td>Pain in muscles (e.g., leg ache)</td>
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<tr>
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<td>Pain in joints (e.g., knee ache)</td>
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<tr>
<td><strong>ENERGY</strong></td>
<td>Fatigue, sluggishness</td>
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<td>Apathy, lethargy</td>
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<td><strong>MIND/EMOTIONS</strong></td>
<td>Inattentiveness or poor concentration</td>
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<td>Mood swings</td>
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<td>Anxiety, nervousness</td>
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<td>Aggressiveness (e.g., hitting, kicking, biting)</td>
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<td>Crying or weepiness</td>
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<td>Tantrums</td>
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<td>Hyperactivity</td>
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<tr>
<td><strong>OTHER</strong></td>
<td>Frequent urination</td>
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<td>Itching of anus or genitals</td>
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<td>Bed wetting</td>
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<td>Wetting or soiling of clothes</td>
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<tr>
<td><strong>GRAND TOTAL</strong></td>
<td>TOTAL:</td>
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(Please fill out every 2 weeks and bring with you to follow-up visits)