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 please include them in any area which are appropriate.

If your child is old enough, please ask them to participate in filling out the form, particularly the REVIEW OF SYMPTOMS. The form 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.

Please fill out the form in **BLACK ink** as it is scanned into the chart.

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:

Referral 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

______________________________________________    _______________________________________
______________________________________________    _______________________________________
______________________________________________    _______________________________________
______________________________________________    _______________________________________

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? (GOALS)
1. _____________________________________________________________________________
2. _____________________________________________________________________________
3. _____________________________________________________________________________

When was the last time you felt your child was well? (ONSET of problem) ________________

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: (USE BACK IF NEEDED) ____________

<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></td>
<td></td>
<td>Elimination Diet</td>
<td>X</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Pediatric Medical Questionnaire

**Medical History**

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

### GASTROINTESTINAL

<table>
<thead>
<tr>
<th>Past</th>
<th>Current</th>
<th>Medical Condition</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td>☐</td>
<td>Irritable Bowel Syndrome</td>
</tr>
<tr>
<td>☐</td>
<td>☐</td>
<td>Inflammatory Bowel Disease</td>
</tr>
<tr>
<td>☐</td>
<td>☐</td>
<td>Crohn’s</td>
</tr>
<tr>
<td>☐</td>
<td>☐</td>
<td>Ulcerative Colitis</td>
</tr>
<tr>
<td>☐</td>
<td>☐</td>
<td>Gastritis or Peptic Ulcer Disease</td>
</tr>
<tr>
<td>☐</td>
<td>☐</td>
<td>GERD (reflux)</td>
</tr>
<tr>
<td>☐</td>
<td>☐</td>
<td>Celiac Disease</td>
</tr>
<tr>
<td>☐</td>
<td>☐</td>
<td>Other</td>
</tr>
</tbody>
</table>

### CARDIOVASCULAR *(provide dates)*

<table>
<thead>
<tr>
<th>Past</th>
<th>Current</th>
<th>Medical Condition</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td>☐</td>
<td>Heart Disease</td>
</tr>
<tr>
<td>☐</td>
<td>☐</td>
<td>Elevated Cholesterol</td>
</tr>
<tr>
<td>☐</td>
<td>☐</td>
<td>Hypertension (high blood pressure)</td>
</tr>
<tr>
<td>☐</td>
<td>☐</td>
<td>Rheumatic Fever</td>
</tr>
<tr>
<td>☐</td>
<td>☐</td>
<td>Mitral Valve Prolapse</td>
</tr>
<tr>
<td>☐</td>
<td>☐</td>
<td>Other</td>
</tr>
</tbody>
</table>

### METABOLIC/ENDOCRINE *(provide dates)*

<table>
<thead>
<tr>
<th>Past</th>
<th>Current</th>
<th>Medical Condition</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td>☐</td>
<td>Type 1 Diabetes</td>
</tr>
<tr>
<td>☐</td>
<td>☐</td>
<td>Type 2 Diabetes</td>
</tr>
<tr>
<td>☐</td>
<td>☐</td>
<td>Hypoglycemia</td>
</tr>
<tr>
<td>☐</td>
<td>☐</td>
<td>Metabolic Syndrome (Insulin Resistance or Pre-Diabetes)</td>
</tr>
<tr>
<td>☐</td>
<td>☐</td>
<td>Hypothyroidism (low thyroid)</td>
</tr>
<tr>
<td>☐</td>
<td>☐</td>
<td>Hyperthyroidism (overactive thyroid)</td>
</tr>
<tr>
<td>☐</td>
<td>☐</td>
<td>Endocrine Problems</td>
</tr>
<tr>
<td>☐</td>
<td>☐</td>
<td>Polycystic Ovarian Syndrome (PCOS)</td>
</tr>
<tr>
<td>☐</td>
<td>☐</td>
<td>Weight Gain</td>
</tr>
<tr>
<td>☐</td>
<td>☐</td>
<td>Weight Loss</td>
</tr>
<tr>
<td>☐</td>
<td>☐</td>
<td>Frequent Weight Fluctuations</td>
</tr>
<tr>
<td>☐</td>
<td>☐</td>
<td>Bulimia</td>
</tr>
<tr>
<td>☐</td>
<td>☐</td>
<td>Anorexia</td>
</tr>
<tr>
<td>☐</td>
<td>☐</td>
<td>Binge Eating Disorder</td>
</tr>
<tr>
<td>☐</td>
<td>☐</td>
<td>Night Eating Syndrome</td>
</tr>
<tr>
<td>☐</td>
<td>☐</td>
<td>Other</td>
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</tbody>
</table>

### CANCER *(provide dates)*

<table>
<thead>
<tr>
<th>Past</th>
<th>Current</th>
<th>Medical Condition</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td>☐</td>
<td>Kidney Stones</td>
</tr>
<tr>
<td>☐</td>
<td>☐</td>
<td>Urinary Tract Infections</td>
</tr>
<tr>
<td>☐</td>
<td>☐</td>
<td>Yeast Infections</td>
</tr>
<tr>
<td>☐</td>
<td>☐</td>
<td>Other</td>
</tr>
</tbody>
</table>

### GENITAL AND URINARY SYSTEMS *(provide dates)*

<table>
<thead>
<tr>
<th>Past</th>
<th>Current</th>
<th>Medical Condition</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td>☐</td>
<td>Kidney Stones</td>
</tr>
<tr>
<td>☐</td>
<td>☐</td>
<td>Urinary Tract Infections</td>
</tr>
<tr>
<td>☐</td>
<td>☐</td>
<td>Yeast Infections</td>
</tr>
<tr>
<td>☐</td>
<td>☐</td>
<td>Other</td>
</tr>
</tbody>
</table>

### MUSCULOSKELETAL/PAIN *(provide dates)*

<table>
<thead>
<tr>
<th>Past</th>
<th>Current</th>
<th>Medical Condition</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td>☐</td>
<td>Arthritis</td>
</tr>
<tr>
<td>☐</td>
<td>☐</td>
<td>Fibromyalgia</td>
</tr>
<tr>
<td>☐</td>
<td>☐</td>
<td>Chronic Pain</td>
</tr>
<tr>
<td>☐</td>
<td>☐</td>
<td>Other</td>
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</tbody>
</table>

### INFLAMMATORY/AUTOIMMUNE *(provide dates)*

<table>
<thead>
<tr>
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<th>Current</th>
<th>Medical Condition</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td>☐</td>
<td>Chronic Fatigue Syndrome</td>
</tr>
<tr>
<td>☐</td>
<td>☐</td>
<td>Autoimmune Disease</td>
</tr>
<tr>
<td>☐</td>
<td>☐</td>
<td>Rheumatoid Arthritis</td>
</tr>
<tr>
<td>☐</td>
<td>☐</td>
<td>Lupus SLE</td>
</tr>
<tr>
<td>☐</td>
<td>☐</td>
<td>Immune Deficiency Disease</td>
</tr>
<tr>
<td>☐</td>
<td>☐</td>
<td>Severe Infectious Disease</td>
</tr>
<tr>
<td>☐</td>
<td>☐</td>
<td>Poor Immune Function (frequent infections)</td>
</tr>
<tr>
<td>☐</td>
<td>☐</td>
<td>Food Allergies</td>
</tr>
<tr>
<td>☐</td>
<td>☐</td>
<td>Environmental Allergies</td>
</tr>
<tr>
<td>☐</td>
<td>☐</td>
<td>Multiple Chemical Sensitivities</td>
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<tr>
<td>☐</td>
<td>☐</td>
<td>Latex Allergy</td>
</tr>
<tr>
<td>☐</td>
<td>☐</td>
<td>Other</td>
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</tbody>
</table>

### RESPIRATORY DISEASES *(provide dates)*

<table>
<thead>
<tr>
<th>Past</th>
<th>Current</th>
<th>Medical Condition</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td>☐</td>
<td>Frequent Ear Infections</td>
</tr>
<tr>
<td>☐</td>
<td>☐</td>
<td>Frequent Upper Respiratory Infections</td>
</tr>
<tr>
<td>☐</td>
<td>☐</td>
<td>Asthma</td>
</tr>
</tbody>
</table>
# Pediatric Medical Questionnaire

<table>
<thead>
<tr>
<th>Chronic Sinusitis</th>
<th>Auditory Evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bronchitis</td>
<td>Vision Evaluation</td>
</tr>
<tr>
<td>Sleep Apnea</td>
<td>Osteopathic</td>
</tr>
<tr>
<td>Other</td>
<td>Acupuncture</td>
</tr>
<tr>
<td></td>
<td>Physical Therapy</td>
</tr>
<tr>
<td></td>
<td>Occupational Therapy</td>
</tr>
<tr>
<td></td>
<td>Sensory Integration Therapy</td>
</tr>
<tr>
<td></td>
<td>Language Classes</td>
</tr>
<tr>
<td></td>
<td>Sign Language</td>
</tr>
<tr>
<td></td>
<td>Homeopathic</td>
</tr>
<tr>
<td></td>
<td>Naturopathic</td>
</tr>
<tr>
<td></td>
<td>Craniosacral</td>
</tr>
<tr>
<td></td>
<td>Chiropractic</td>
</tr>
<tr>
<td></td>
<td>MRI</td>
</tr>
<tr>
<td></td>
<td>CT Scan</td>
</tr>
<tr>
<td></td>
<td>Upper Endoscopy</td>
</tr>
<tr>
<td></td>
<td>Upper GI Series</td>
</tr>
<tr>
<td></td>
<td>Ultrasound</td>
</tr>
</tbody>
</table>

### SKIN DISEASES (provide dates)

<table>
<thead>
<tr>
<th>Past</th>
<th>Current</th>
<th>Eczema</th>
<th>Psoriasis</th>
<th>Acne</th>
<th>Other</th>
</tr>
</thead>
</table>

### NEUROLOGIC/MOOD (provide dates)

<table>
<thead>
<tr>
<th>Past</th>
<th>Current</th>
<th>Depression</th>
<th>Anxiety</th>
<th>Bipolar Disorder</th>
<th>Schizophrenia</th>
<th>Headaches</th>
<th>Migraines</th>
<th>ADD/ADHD</th>
<th>Sensory Integrative Disorder</th>
<th>Autism</th>
<th>Mild Cognitive Impairment</th>
<th>Multiple Sclerosis</th>
<th>ALS</th>
<th>Seizures</th>
<th>Other Neurological Problems</th>
</tr>
</thead>
</table>

### INJURIES (provide dates)

<table>
<thead>
<tr>
<th>Past</th>
<th>Current</th>
<th>Back injury</th>
<th>Neck Injury</th>
<th>Head Injury</th>
<th>Broken Bones</th>
<th>Other</th>
</tr>
</thead>
</table>

### SURGERIES (provide dates)

<table>
<thead>
<tr>
<th>Past</th>
<th>Current</th>
<th>Appendectomy</th>
<th>Circumcision</th>
<th>Hernia</th>
<th>Tonsils</th>
<th>Adenoids</th>
<th>Dental Surgery</th>
<th>Tubes in Ears</th>
<th>Other</th>
</tr>
</thead>
</table>

### PREVIOUS EVALUATIONS (provide dates)

<table>
<thead>
<tr>
<th>Past</th>
<th>Current</th>
<th>Full Physical Exam</th>
<th>Psychological Evaluations</th>
<th>Wechsler Preschool &amp; Primary Scale of Intelligence</th>
<th>Speech and Language Evaluations</th>
<th>Genetic Evaluation</th>
<th>Neurological Evaluations</th>
<th>Gastroenterology Evaluations</th>
<th>Celiac/Gluten testing</th>
<th>Allergy Evaluation</th>
<th>Nutritional Evaluation</th>
</tr>
</thead>
</table>

### BLOOD TYPE:
- A
- B
- AB
- O
- Rh+
- Unknown
Pediatric Medical Questionnaire

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?  Which:?  ○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?  (please detail)  ○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>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

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? ________________________________________________

WHILE TRAVELING: Ever had severe: ☐ Gastroenteritis ☐ Diarrhea FROM a trip outside of the USA?

### 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_______________

☐ Drink coffee_______________

☐ Smoke tobacco_______________

☐ 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____

☐ 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: ________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________

PERINATAL
Pregnancy duration: X 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 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 □ None
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
Is the impression strong? ○Yes ○No
Pediatric Medical Questionnaire

DEVELOPMENTAL HISTORY (important if under age 10)

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

<table>
<thead>
<tr>
<th>Milestone</th>
<th>Age in Months</th>
<th>Never</th>
<th>First Words</th>
<th>Age in Months</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sitting up</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crawl</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pulled to stand</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Potty trained</td>
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<td>Walked alone</td>
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<tr>
<td>Dry at night</td>
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MEDICATIONS

Current Medications □ None

<table>
<thead>
<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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Previous Medications: Last 10 years (attach list if appropriate)

<table>
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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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</tbody>
</table>

Nutritional Supplements (Vitamins/Minerals/Herbs/Homeopathy) □ None

<table>
<thead>
<tr>
<th>Supplementation and Brand</th>
<th>Dose</th>
<th>Frequency</th>
<th>Start Date (month/year)</th>
<th>Reason for Use</th>
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</table>
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>Mother</th>
<th>Father</th>
<th>Brother(s)</th>
<th>Sister(s)</th>
<th>Children</th>
<th>Maternal Grandparent</th>
<th>Paternal Grandparent</th>
<th>Aunts</th>
<th>Uncles</th>
<th>Other</th>
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<tbody>
<tr>
<td><strong>Age (if still alive)</strong></td>
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<tr>
<td><strong>Age at death (if deceased)</strong></td>
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<td><strong>Cancers</strong></td>
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<td>Colon Cancer</td>
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<td>Breast or Ovarian Cancer</td>
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<td>Obesity</td>
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<td>Diabetes</td>
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<tr>
<td>Inflammatory Arthritis (rheumatoid, Psoriatic, Ankylosing Spondylitis)</td>
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<td>Inflammatory Bowel Disease</td>
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<td>Multiple Sclerosis</td>
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<td>Auto Immune Disease (such as Lupus)</td>
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<td>Irritable Bowel Syndrome</td>
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<td>Celiac Disease (Wheat Sensitivity)</td>
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<td>Eczema / Psoriasis</td>
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<td>Food Allergies, Sensitivities or Intolerances</td>
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<td>Dementia</td>
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<td>Parkinson’s</td>
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<td>ALS or other Motor Neuron Diseases</td>
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<td>Genetic Disorders</td>
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<td>Substance Abuse (such as alcoholism)</td>
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<td>Autism</td>
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<td>Bipolar Disease</td>
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<td><strong>OTHER</strong> Family Diseases: (list below)</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 (include dates, results) ________________________________________________________________

Does your child follow a special diet or nutritional program? Check all that apply:  ○ Yes  ○ No
☐ 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.): __________________________

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 current lifestyle and eating habits:

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

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: ________________________________________________
Pediatric Medical Questionnaire

Please describe any other eating concerns that you have regarding your child: ______________________
______________________________________________________________________________________

ACTIVITY

List type and amount of activity daily:

<table>
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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 (INCLUDE DATES)

□ None

EXPOSURES

<table>
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<tr>
<th>Past</th>
<th>Current</th>
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<tbody>
<tr>
<td>□</td>
<td>□</td>
<td>Mold in bathroom</td>
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<td>□</td>
<td>□</td>
<td>Damp cellar</td>
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<td>□</td>
<td>□</td>
<td>Pest extermination – Inside</td>
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<td>□</td>
<td>□</td>
<td>Pest extermination – Outside</td>
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<td>□</td>
<td>□</td>
<td>Forced hot air heat</td>
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<td>□</td>
<td>□</td>
<td>Had water in basement</td>
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<td>□</td>
<td>□</td>
<td>Mold visible on exterior of house</td>
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<td>□</td>
<td>□</td>
<td>Heavily wooded or damp surroundings</td>
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<td>□</td>
<td>□</td>
<td>Mold in cellar, crawl space, or basement</td>
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<td>□</td>
<td>□</td>
<td>Mold, musty school/daycare</td>
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<td>□</td>
<td>Tobacco smoke</td>
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<td>□</td>
<td>Well water</td>
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<td>□</td>
<td>Carpet in bedroom</td>
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<td>□</td>
<td>□</td>
<td>Carpet in most parts of house</td>
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<td>Feather or down bedding</td>
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</table>

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 __________________________
PHYSICAL □ None
☐ 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
☐ Perspiration - odd odor
☐ 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 □ None
☐ 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

DAK 70119
**Pediatric Medical Questionnaire**

**DIGESTIVE (cont)**
- 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 □ None**
- Poor appetite
- Thirst
- Extreme water drinking
- Binging
- 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

**BEHAVIOR □ None**
- Food coloring intolerance
- Gluten Intolerance
- Casein intolerance
- Specific food(s) intolerance
- Lactose intolerance
- Behavior worse with food
- Behavior better when fasting

**MOOD □ None**
- 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 □ None**
- 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
Pediatric Medical Questionnaire

SENSORY (cont)
☐ Examines by smell
☐ Intensely aware of odors
☐ Blinking
☐ Bothered by bright lights
☐ Distorted vision
☐ Conjunctivitis
☐ Eye crustng
☐ 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 □ None
☐ 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/limb
☐ 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 □ None
☐ 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 □ None
☐ 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 □ None
☐ Girls: Early first period
☐ Boys: Large testicles
☐ Early breast development
☐ Early pubic hair
☐ Girls: vaginal odor

URINARY □ None
☐ Frequent urination
☐ Bed wetting after age 4
☐ Odd urinary odor
☐ Urinary hesitancy
☐ Urinary tract infections
☐ Urinary urgency
☐ Dry at night

OTHER □ None
☐ Seizures - focal
☐ Seizures - generalized
☐ Seizures - grand mal
☐ Seizures - petit mal
☐ Unusual fast heart beat
☐ Heart murmur
☐ Headaches
☐ Joint pains
☐ Leg pains
☐ Muscle pains

DAK 70119

15
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 - ○5 ○4 ○3 ○2 ○1
- Taking several nutritional supplements each day - ○5 ○4 ○3 ○2 ○1
- Keeping a record of everything eaten each day - ○5 ○4 ○3 ○2 ○1
- Modifying lifestyle (e.g., 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
- Have 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? (barriers) ____________________________________________

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? - ○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 child’s health program? – ○5 ○4 ○3 ○2 ○1

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

○5 ○4 ○3 ○2 ○1

Comments_______________________________________________________________
Pediatric Medical Questionnaire

5-DAY DIET DAIRY INSTRUCTIONS (Black PEN please)

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 _______________________

**DAY 1 (If special foods used (eg Gluten Free) please indicate – GF etc)**

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Bowel Movements (#, form, color)_________________________________________________________
Stress/Mood/Emotions _________________________________________________________________
Other Comments________________________________________________________________________
Other _________________________________________________________________________________

DAX 70119
# 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 __________________________________________________________________
Pediatric Medical Questionnaire

Other Comments

**DAY 4**

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Bowel Movements (#, form, color)

Stress/Mood/Emotions

Other Comments

Other

**DAY 5**

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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.

**POINTSCALE**
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 or feeling full
- 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 ______**

**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
Additional Comments. (Please identify page if from earlier section)