Youth Health History Questionnaire

(To be completed by patient's parent)

Name: _____ Date: _____

Date of Birth: _____ Age: _____ Sex: M / F (circle one)

Weight: _____ Height: _____

Chief Complaint(s) / Reason for this visit: _____

_____

_____

_____

Prescription Drug Usage - Is your child presently receiving any medications? YES NO

Please list the exact names of any medications your child is currently using:

_____

_____

_____

Is your son or daughter allergic to any drugs that you know of? (If so please list names):

_____

_____

Supplement/Vitamin Usage – Please list any supplements/vitamins your child is currently taking:

_____

_____

_____

Lifestyle

Dietary Habits: Describe the foods your child normally eats:

BREAKFAST: _____

LUNCH: _____

DINNER: _____

SNACKS: _____

Lifestyle, Cont'd

Does your child consume the following? If so, how much?

1. Soda or carbonated beverages? YES NO _____
2. White flour products? YES NO _____
3. Fried foods? YES NO _____
4. Fast foods regularly? YES NO _____
5. Sweets and/or refined carbohydrates? YES NO _____
6. Dairy or milk products? YES NO _____
7. Juice? YES NO _____
8. Meat/Fish? YES NO _____

Is your child a vegetarian? YES NO
How much water does your child drink daily? _____
Are there smokers in your child's home? YES NO
Is your child physically active daily? YES NO
Please list what types of physical activity and/or sports that your child participates in:
_____

History

As a baby, did your child have colic? YES NO
As a baby, how was your child fed? *(Please circle breast or formula)*
BREAST How long? _____
FORMULA What kind? _____ How long? _____

Does your child have a history of ear infections? YES NO
If yes, at what age did the first earache occur? _____
How frequently did/does your child have earaches? _____
In which ear do your child's earaches/infections usually occur? RIGHT LEFT BOTH
Were/Are your child's earaches/infections generally treated with antibiotics? YES NO

Is your child allergic to anything? YES NO
If yes, please explain: _____
Does your child have asthma? YES NO Any history of anemia? YES NO

Has your child been vaccinated? YES NO
Has he/she been vaccinated recently? YES NO
If yes, please list any known reactions to past or recent vaccinations: _____
_____
_____

Please list any hospital procedures/surgeries that your child has had: _____
_____

History, Cont'd

Are there any known health conditions that your child has been diagnosed with? YES NO
If yes, please explain: _____
_____
_____

Sleep

How well does your child sleep?
□Well □ Trouble falling asleep □ Trouble staying asleep □ Insomnia

What is the average number of hours your child most often sleeps each night? _____

When your child wakes in the morning does he/she still feel tired? YES NO
If yes, how often? _____

Do you keep your child's room completely dark at night? YES NO

Does your child take naps? YES NO

How often would you say your child has nightmares, if at all? NEVER SOMETIMES OFTEN

Signs & Symptoms *(INSTRUCTIONS: To the best of your ability circle the number that best describes the intensity of your child's current symptoms. 1 = Mild (happens approximately once per month), 2 = Moderate (happens approximately weekly), 3 = Severe (happens almost daily). If you do not know the answer to a question or if it does not pertain to your child simply leave it blank.*

Section 1:

Does your child experience bloating?	1	2	3
Fullness for extended time after meals?	1	2	3
Fatigue or low energy after eating?	1	2	3
Does he/she experience indigestion?	1	2	3
Uncomfortable/adverse reactions to food?	1	2	3
Weight gain / weight loss? (circle)	1	2	3
Trouble losing weight?	1	2	3
Belching/gas? (circle)	1	2	3
Stomach burning/nausea? (circle)	1	2	3

Signs & Symptoms, Cont'd *(INSTRUCTIONS: To the best of your ability circle the number that best describes the intensity of your child's current symptoms. 1 = Mild (happens approximately once per month), 2 = Moderate (happens approximately weekly), 3 = Severe (happens almost daily). If you do not know the answer to a question or if it does not pertain to your child simply leave it blank.*

Section 2:

Sweet cravings/carbohydrate cravings? (circle)	1	2	3
Constant hunger?	1	2	3
Never hungry/anorexia? (circle)	1	2	3

Section 3:

Does your child suffer with constipation?	1	2	3
Light colored stool?	1	2	3
Loose stools?	1	2	3
Diarrhea?	1	2	3
Persistent gas?	1	2	3
Digestive problems?	1	2	3
Frequent urination?	1	2	3
Bedwetting?	1	2	3

Section 4:

Low mood/depression?	1	2	3
Irritability?	1	2	3
Anxiety?	1	2	3
Anger/aggression?	1	2	3
Nervousness?	1	2	3
Overly reactive?	1	2	3
Short fuse?	1	2	3
Behavior problems?	1	2	3
Fear?	1	2	3

Section 5:

Discouragement/pessimism? (circle)	1	2	3
Decreased interest in activities/relationships?	1	2	3
Decreased initiative/motivation/drive?	1	2	3
Decreased productivity at school or home?	1	2	3

Signs & Symptoms, Cont'd *(INSTRUCTIONS: To the best of your ability circle the number that best describes the intensity of your child's current symptoms. 1 = Mild (happens approximately once per month), 2 = Moderate (happens approximately weekly), 3 = Severe (happens almost daily). If you do not know the answer to a question or if it does not pertain to your child simply leave it blank.*

Section 6:

Concentration problems?	1	2	3
Poor memory?	1	2	3
Foggy thinking?	1	2	3
Increased fatigue?	1	2	3
Lowered self-esteem/self image?	1	2	3
Sadness?	1	2	3
Crying?	1	2	3
Reserved/withdrawn?	1	2	3

Section 7:

Decrease in stamina or poor stamina?	1	2	3
Decrease in athletic performance?	1	2	3
Muscle soreness/weakness?	1	2	3
Body/joint aches?	1	2	3
Persistent leg cramps?	1	2	3
Growing pains?	1	2	3
Headaches/migraines? (circle)			