

Child Health Questionnaire

Parent's Name: _____

Date: _____

Child's Name: _____

Child's Age: _____

Instructions: Circle the number 3 if the symptom your child experiences is MORE NOTICEABLE to you—possibly on a weekly basis or more. Circle the number 1 if you child has the symptom and it is LESS NOTICEABLE to you—possibly less than once a week. If your child has not had the symptom in 3 months please leave it blank. Please notice that some of the symptoms are listed below in multiple sections; please make sure you fill them out in both sections.

IT/LIVER

Stomach aches	1	3	Intestinal gas	1	3	Anal burning	1	3
Anal itching	1	3	Constipation	1	3	Diarrhea	1	3
Coated tongue	1	3	Nausea	1	3	Stomach bloating	1	3
Watery stools	1	3	Hates meat	1	3	Itching skin	1	3
Craves sweets	1	3	Passes lots of gas	1	3	Dark circles under eyes	1	3
Food allergies	1	3						

How many times has your child taken antibiotics since birth? 1 to 2 times 3 to 4 times 5 to 6 times More than 6

S/FOOD/INT

Behavior changes shortly after eating sweets or other foods	1	3
Has a strong desire to eat sweets almost like a craving	1	3
Eats more carbohydrates than protein	1	3
Doesn't eat much or hates to eat	1	3
Irritable in the morning	1	3
Doesn't want to go to bed	1	3
Skin flushes or turns red (not related to exercise)	1	3
Ears turn red (not related to coldness outside or exercise)	1	3
Dark circles under eyes	1	3
Food allergies	1	3
Pale skin	1	3
Ear Infections	1	3
Asthma	1	3

G/G

Tired	1	3	Hard to focus	1	3
Glazed over look when talking to them	1	3	Doesn't want to play sports	1	3
Doesn't want to exercise	1	3	Sinus troubles	1	3
Gets sick more than twice a year	1	3	Allergies (environmental)	1	3
Pale skin	1	3	Ear Infections	1	3
Asthma	1	3	Would rather sit inside then play outside	1	3

AA

Depressed	1	3	Irritable	1	3	Frustrated easily	1	3
Anxious	1	3	Worries	1	3	Lethargic	1	3
Problems focusing	1	3						

II

List the number of metal fillings in your child's mouth _____

Do you use pesticides in your home? Yes No If yes, how often is the home sprayed? _____

Has your child had all their vaccinations? Yes No Do you have well water? Yes No

Does your child drink out of plastic water bottles? Yes No Do you microwave in plastic? Yes No

Is there any type of filtration system on your home water? Yes No If yes what kind? _____