



HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name <i>(Last, First, M.I.):</i>	<input type="checkbox"/> M <input type="checkbox"/> F	DOB:
Address:		
Primary care physician:	Date last seen by PCP:	

PARENTS INFORMATION

	MOTHER	FATHER
ADDRESS:		
PHONE NUMBER:		
EMAIL ADDRESS:		

Was it a normal pregnancy? Yes No **Was it a normal delivery?** Yes No **Was labor induced?** Yes No **Drug?** _____

(please describe)

Medical: (please describe)

Frequency of and age of first ear infection?

Asthma or allergies?

Accidents or trauma?

Hospitalizations/Surgeries?

Antibiotics given? 1-3 times 4-7 times 8-10 (more) Probiotics given?

Is the child ever been or currently taking any prescription drugs? _____

Development: (please describe)

Age at which you suspected something was unusual? _____ Please describe.

Age at which your child rolled over? _____ Age at which your child walked? _____ Words used by 1st birthday? _____

Did your child ever lose spoken words? If so, please describe speech regression.

Did your child lose social and/or motor skills?

Was your child vaccinated? If so, up to what age?

Did you associate any regression with a vaccine?

Please turn to next page

Development (Cont.)		
Did your child breast feed? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, Length of time? _____ If no, brand of formula? _____		
Did your child have Colic? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please describe? _____		
At what age was solid food introduced? _____ What were the foods your child favored? _____		
Is your child potty trained? Yes <input type="checkbox"/> No <input type="checkbox"/> If so, at what age? _____ Are bowels normal? Yes <input type="checkbox"/> No <input type="checkbox"/>		
Does your child experience: Bloating? Yes <input type="checkbox"/> No <input type="checkbox"/> Belching? Yes <input type="checkbox"/> No <input type="checkbox"/> Constipation? Yes <input type="checkbox"/> No <input type="checkbox"/> Diarrhea? Yes <input type="checkbox"/> No <input type="checkbox"/>		
Does your child self-injure? Yes <input type="checkbox"/> No <input type="checkbox"/> If so, please describe _____		
Does your child cover their ears or show auditory defensive behavior? Yes <input type="checkbox"/> No <input type="checkbox"/>		
Does your child handle crowded places well? Yes <input type="checkbox"/> No <input type="checkbox"/>	Is your child Right or Left handed? _____	Is your child verbal? Yes <input type="checkbox"/> No <input type="checkbox"/>
Is brushing teeth, or brushing hair an issue? Yes <input type="checkbox"/> No <input type="checkbox"/>	Does your child have sensitivity to shirt tags or clothing items? Yes <input type="checkbox"/> No <input type="checkbox"/>	Does your child have OCD behaviors? Yes <input type="checkbox"/> No <input type="checkbox"/> (rituals, lining things up, "stuck" on things)
Sleep pattern: (please describe)		

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.				
Stemming	<input type="checkbox"/> 1%-24% of the day			
	<input type="checkbox"/> 25%-50% of the day			
	<input type="checkbox"/> 50%-75% of the day			
	<input type="checkbox"/> 75%-100% of the day			
Diet	Are any vegetables eaten on a daily basis? If yes, which ones? _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	Is patient on Dairy? (cow's milk) If not, what kind of milk does your child drink? _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Favorite- Lease favorite-	Please list below top 4 favorite foods and top 4 least favorite foods.			
	1.	2.	3.	4.
Water	1.	2.	3.	5.
	<input type="checkbox"/> None	<input type="checkbox"/> 1 glass per day	<input type="checkbox"/> 2-3 glasses per day	<input type="checkbox"/> 4-7 glasses per day
Does your child drink cola or juice? Yes <input type="checkbox"/> No <input type="checkbox"/>				
Therapy	Have you tried other therapies in the past?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	If yes, what kind? _____			
	What type of school/educational program is your child enrolled in currently? _____			
	Does your child have an IEP?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	Is your child currently in speech therapy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	Is your child currently in occupational therapy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	Is your child currently in social/emotional therapy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	Is your child currently in ABA therapy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
RX Drugs/	Is your child currently on any prescription drug? If yes, please list below.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

Natural Supplements	Is your child on any supplements? If yes, please list below.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Self Help Skills	Does your child get dressed on his/her own?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Does your child brush his/her own teeth?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Does your child have problems with fine motor i.e. buttons, zippers, show laces, etc?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			Children	<input type="checkbox"/> M <input type="checkbox"/> F	
Mother				<input type="checkbox"/> M <input type="checkbox"/> F	
Sibling	<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> M <input type="checkbox"/> F	
	<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> M <input type="checkbox"/> F		
	<input type="checkbox"/> M <input type="checkbox"/> F		Grandmother <i>Maternal</i>		
	<input type="checkbox"/> M <input type="checkbox"/> F		Grandfather <i>Maternal</i>		
	<input type="checkbox"/> M <input type="checkbox"/> F		Grandmother <i>Paternal</i>		
	<input type="checkbox"/> M <input type="checkbox"/> F		Grandfather <i>Paternal</i>		

OTHER PROBLEMS

Check if your child have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

<input type="checkbox"/> Skin	<input type="checkbox"/> Chest/Heart	<input type="checkbox"/> Recent changes in:
<input type="checkbox"/> Head/Neck	<input type="checkbox"/> Back	<input type="checkbox"/> Weight
<input type="checkbox"/> Ears	<input type="checkbox"/> Intestinal	<input type="checkbox"/> Energy level
<input type="checkbox"/> Nose	<input type="checkbox"/> Bladder	<input type="checkbox"/> Ability to sleep
<input type="checkbox"/> Throat	<input type="checkbox"/> Bowel	<input type="checkbox"/> Other pain/discomfort:
<input type="checkbox"/> Lungs	<input type="checkbox"/> Circulation	

Parent's signature: _____ Parent's Printed Name: _____ Date: ___/___/_____

Parent's signature: _____ Parent's Printed Name: _____ Date: ___/___/_____