HEALTH HISTORY QUESTIONNAIRE

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

Name *(Last, First, M.I.):* ☐ M ☐ 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 describible)

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 ☐ No ☐ If yes, Length of time? _____ If no, brand of formula? _____		
Did your child have Colic? Yes ☐ No ☐ If yes, please describe?		
At what age was solid food introduced? _____ What were the foods your child favored? _____		
Is your child potty trained? Yes ☐ No ☐ If so, at what age? _____ Are bowels normal? Yes ☐ No ☐ _____		
Does your child experience: Bloating? Yes ☐ No ☐ Belching? Yes ☐ No ☐ Constipation? Yes ☐ No ☐ Diarrhea? Yes ☐ No ☐		
Does your child self-injure? Yes ☐ No ☐ If so, please describe _____		
Does your child cover their ears or show auditory defensive behavior? Yes ☐ No ☐ _____		
Does your child handle crowded places well? Yes☐No☐	Is your child Right or Left handed? _____	Is your child verbal? Yes ☐ No ☐
Is brushing teeth, or brushing hair an issue? Yes ☐ No ☐	Does your child have sensitivity to shirt tags or clothing items? Yes ☐ No ☐	Does your child have OCD behaviors? Yes☐ No☐ (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	☐ 1%-24% of the day					
	☐ 25%-50% of the day					
	☐ 50%-75% of the day					
	☐ 75%-100% of the day					
Diet	Are any vegetables eaten on a daily basis? If yes, which ones? _____				☐ Yes	☐ No
	Is patient on Dairy? (cow's milk) If not, what kind of milk does your child drink? _____				☐ Yes	☐ No
Favorite-	Please list below top 4 favorite foods and top 4 least favorite foods.					
	1.	2.	3.	4.		
Lease favorite-	1.	2.	3.	5.		
Water	☐ None	☐ 1 glass per day	☐ 2-3 glasses per day	☐ 4-7 glasses per day		
	Does your child drink cola or juice? Yes ☐ No ☐ _____					
Therapy	Have you tried other therapies in the past?				☐ Yes	☐ No
	If yes, what kind?_____					
	What type of school/educational program is your child enrolled in currently? _____					
	Does your child have an IEP?				☐ Yes	☐ No
	Is your child currently in speech therapy?				☐ Yes	☐ No
	Is your child currently in occupational therapy?				☐ Yes	☐ No
	Is your child currently in social/emotional therapy?				☐ Yes	☐ No
	Is your child currently in ABA therapy?				☐ Yes	☐ No
RX Drugs/	Is your child currently on any prescription drug? If yes, please list below.				☐ Yes	☐ No

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

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Children**	☐ M ☐ F	
Mother				☐ M ☐ F	
Sibling	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		**Grandmother** *Maternal*		
	☐ M ☐ F		**Grandfather** *Maternal*		
	☐ M ☐ F		**Grandmother** *Paternal*		
	☐ M ☐ F		**Grandfather** *Paternal*		

OTHER PROBLEMS

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

☐ Skin	☐ Chest/Heart	☐ Recent changes in:
☐ Head/Neck	☐ Back	☐ Weight
☐ Ears	☐ Intestinal	☐ Energy level
☐ Nose	☐ Bladder	☐ Ability to sleep
☐ Throat	☐ Bowel	☐ Other pain/discomfort:
☐ Lungs	☐ Circulation	

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

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