

Patient name: _____
Patient's Date of Birth (mm/dd/yyyy) _____
Today's Date: _____

Healing the Whole Child Preliminary Questionnaire

Please answer those items that apply to your child, and add the requested information.

Prenatal:

During your pregnancy, did you take: *(check all that apply)*

- Prenatal vitamins
- Omega 3 supplement (DHA, cod liver oil, flax seed oil, etc.)
- Medications: _____
- Other: _____

Did you have any issues with infertility? Yes No *(please explain)* _____

During your pregnancy, did you have: *(check all that apply)*

- Positive Group B Strep status
 - Yeast infections
 - Any trauma
 - Any toxic exposures
 - Issues with preterm labor
 - Acute or chronic illness: *(please explain)* _____
 - Other complications: _____
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During your pregnancy, did you receive: *(check all that apply)*

- Antibiotics (by IV or by mouth) during pregnancy or delivery
- Rhogam shots for RH negative blood type
- Immunization during your pregnancy, including the flu vaccine
- Steroids, for acute/chronic illness or for preterm labor

Birth:

How was your baby was born: Vaginally C-section

Was your baby born full-term? Yes No

If no, what was your baby's gestational age at birth? _____

Did your baby receive or require any treatment while in the hospital: *(check all that apply)*

- Resuscitation Antibiotics Steroids Immunization
- Other medications Care in the NICU

If your baby required NICU care, please explain the health issues and the care provided: _____

Infancy:

What did you feed your child as a baby?

- Breast milk: How old was he/she when you stopped? _____
- Formula: What kind? _____

Was your child colicky? Yes No

Did you give infant vitamins? Yes No

At what age was your child first fed:

Solids _____ (Baby cereal is usually the first solid food fed)

Dairy _____ (Milk, yogurt, cheese, ice cream, etc.)

Wheat _____ (Cheerios, teething cookies, crackers, bread, cake, etc.)

Eggs _____

Did your child get frequent diaper rashes? Yes No

Did your child have any yeast infections (thrush, rash)? Yes No

Did your child have any sleep issues after 6 months old? Yes No

Did your child have any negative reactions to immunizations? Yes No

Did your child or does your child have any issues with stooling? *(check all that apply)*

- Loose stools Hard stools Diarrhea Constipation
- Frequent stools Infrequent stools Blood in stool Mucous in stool

How often does your child have a bowel movement? _____

At what age did your child start in daycare or preschool? _____

Allergies and Illness:

Has your child had any negative reactions to food, or true food allergies? Yes No

Has your child been tested and found to be allergic or intolerant to any foods? Yes No

If yes, list the food and reaction: *(ex. rash, vomiting, diarrhea, difficulty breathing, anaphylaxis, test +)*

Please list any chronic illness or recurrent problems that your child has *(ex: asthma, diabetes, etc.)*:

Please list any infections and/or illnesses your child has had and the treatment:

Please list any hospitalizations or surgeries: _____

Please describe any concerns that you have regarding your child's development: _____

Exposures:

Do you have any pets? Yes No If yes, what kind? _____

Have you and/or your child traveled outside the US? Yes No

Do you have any relatives outside the US who visit? Yes No

Do you use any products, herbs, spices, etc., from another country? Yes No

Please check potential exposures in your home now or since your child's birth: *(check all that apply)*

- Cigarette/cigar smoke
- Mold or mildew in home/Leaky roof or basement
- Home located near a factory, farm or golf course
- Home located near major power lines
- Current or recent remodeling of an older home
- Broken mercury thermometer in home
- Older home (built before 1970) with chipping paint
- A parent who works in a factory or works with lead (leaded glass, pewter)
- A parent who works around toxic chemicals, pesticides, heavy metals, etc...
- Mercury "silver" filings in your child's mouth
- Carpet or furniture cleaning
- Use of air fresheners, sanitizers, deodorizers
- Is your child exposed to dry cleaned clothes (ex: they are kept in closets where your child may play)
- Do you use plastic products to store food/ drink or heat food?
- Has your home been tested for radon and was the level elevated?
- Do you have a carbon monoxide detector in your home?
- Other known exposure: _____

What pesticides have been or currently are used in your home: *(check all that apply)*

- Insecticide use in home
- Lice treatment on kids
- Fertilizer or pesticides on grass or in the yard
- Exterminator
- Flea powder or flea treatment on pets

Are there other members in your home with chronic or recurrent illness? Yes No

Family History *(Please check below if there is any family history of illness)*

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Autism | <input type="checkbox"/> Allergies | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Food allergies | <input type="checkbox"/> Headaches | <input type="checkbox"/> Lactose intolerance | <input type="checkbox"/> Celiac disease |
| <input type="checkbox"/> Thyroid disorders | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Multiple Sclerosis (MS) | <input type="checkbox"/> Lupus |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Stroke | <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> Blood clots |
| <input type="checkbox"/> Liver disease | <input type="checkbox"/> Alcoholism | <input type="checkbox"/> MTHFR mutation | <input type="checkbox"/> Infertility |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Bipolar | <input type="checkbox"/> Schizophrenia |
| <input type="checkbox"/> Mental retardation | <input type="checkbox"/> Fragile X | <input type="checkbox"/> Metabolic disorder | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Sickle cell anemia | <input type="checkbox"/> Thalessemia | <input type="checkbox"/> Yeast infections | <input type="checkbox"/> H.Pylori infection |
| <input type="checkbox"/> Stomach ulcers | <input type="checkbox"/> Irritable bowel | <input type="checkbox"/> Ulcerative colitis | <input type="checkbox"/> Crohn's disease |
| <input type="checkbox"/> Giardia | <input type="checkbox"/> Candida | <input type="checkbox"/> TB | <input type="checkbox"/> Lyme disease |
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Immune system disorder: _____ | | |

If there is a family history of cancer, please describe: _____

Other illness not listed above: _____

Diet:

What does your child drink most? _____

How many times a week do you eat out or carry in? _____

How often does your child eat school lunches? _____

How many serving of fruits and vegetables does your child eat each day? _____

How often does your child eat fish and what kind? _____

What percentage of the food you buy is organic? _____

Do you wash your fruits and vegetables? With what? _____

What kind of salt do you use in your home? (iodized salt, Kosher (pickling) salt, Celtic sea salt, etc.)? _____

What oils do you use in your home? (canola, olive oil, butter, margarine, etc.) _____

How do you cook your family's food? (oven, microwave, grill, fried, steamed) _____

Does your child have any particular food or drink cravings or foods that he/she has frequently?
(*please list*): _____

Please keep a general 3-day diet diary. If unable to do so, please list food your child eats most often at each meal.

Breakfast:

Lunch:

Dinner:

Snacks:

Drinks (*provide estimated daily quantity of each*):