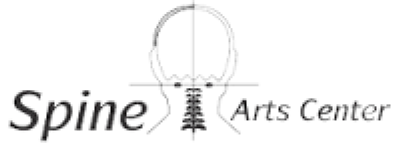

Youth Health History Questionnaire
(To be completed by patient)

Name: ____ Date: __________________

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

Weight: ____________________________________ Height: __________________

Chief Complaint(s):
____
____
____

Prescription Drug Usage – Is your child presently receiving any medication? YES NO

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

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:

____
____
____

<u>Lifestyle</u>

Dietary Habits: Describe the foods you normally eat:
BREAKFAST: ____

LUNCH: ____

DINNER: ____

SNACKS: ____

Lifestyle, Cont'd

Do 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 our 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 o 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
Where/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 vaccination: ______________________________
____
____

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

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

Signs & Symptoms *(INSTRUCTIONS: Circle the number that best describes the intensity of your current symptoms. 1 = Mild (happen approximately once per month) 2 = Moderate (happens weekly), 3 = Severe (happens almost daily).* ***If you do not know the answer to a question or if it does not pertain to you simple 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 your child experience indigestion?	1	2	3
Uncomfortable/adverse reactions to food?	1	2	3
Weight gain?	1	2	3
Trouble losing weight?	1	2	3
Weight loss?	1	2	3
Water retention?	1	2	3
Belching/Gas? (circle)	1	2	3
Stomach burning/Nausea? (circle)	1	2	3

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

Section 2:

Sweet cravings/carbohydrate cravings? (circle)	1	2	3
Constant hunger?	1	2	3
Never hunger/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? (circle)	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? (circle)	1	2	3
Decreased initiative/motivations/drive (circle)	1	2	3
Decreased productivity at school or home?	1	2	3

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? (circle)	1	2	3
Sadness?	1	2	3
Crying?	1	2	3
Reserved/withdrawn?	1	2	3

<u>Signs & Symptoms Continued</u> *(INSTRUCTIONS: Circle the number that best describes the intensity of your current symptoms. 1 = Mild (happen approximately once per month) 2 = Moderate (happens weekly), 3 = Severe (happens almost daily).* ***If you do not know the answer to a question or if it does not pertain to you simple leave it blank.***

Section 7:

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

Section 8:

Elevated cholesterol?	1	2	3
Elevated blood pressure?	1	2	3
Headaches/Migraines? (circle)	1	2	3
Muscle pain/Joint aches/Backache? (circle)	1	2	3

____

Patient/Guardian (Please Print)

_______________________________________ Date: ____________________

Patient/Guardian (Signature)

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