Pediatric Healthy Living Questionnaire
(Less than 5 Years of Age)

PATIENT INFORMATION **Allergies:** _____ **Weight:** _____ **Date:** _____

Patient Information	*First Name* *Middle Name* *Last Name* *Date of Birth* *Height* *Age*
Grade/School	
Home Mail Address	*Street* *Apt.* *City* *State* *Zip Code*
Mother's Information	*Name* *Occupation* *Home Phone* *Cell/Work Phone* *Email Address*
Father's Information	*Name* *Occupation* *Home Phone* *Cell/Work Phone* *Email Address*

REFERRED BY

_____

CURRENT/ON-GOING PROBLEMS

Why are you coming in for help at this particular time? _____

_____

_____

_____

_____

_____

Please List all current and ongoing problems and diagnoses in order of priority:

Describe Problem	*Mild*	*Moderate*	*Severe*	*Prior Treatment/Approach*	*Excellent*	*Good*	*Fair*
	☐	☐	☐		☐	☐	☐
	☐	☐	☐		☐	☐	☐
	☐	☐	☐		☐	☐	☐
	☐	☐	☐		☐	☐	☐
	☐	☐	☐		☐	☐	☐

When did you first notice problems? _____

_____

_____

_____

_____

_____

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FOOD HISTORY

Typical Breakfast	
Typical Lunch	
Typical Dinner	
Snacks	
Favorite Foods	
Food Intolerances	

GENERAL QUESTIONS

Does your child sleep well?	☐ *Yes* ☐ *No*
*If **no** please describe:* _____	
How may hours does your child sleep per night?	
Does your child snore?	☐ *Yes* ☐ *No*

MEDICAL HISTORY

Blood Type – Please check applicable box.

☐	A	☐	B
☐	AB	☐	O
☐	Don't Know		

PREVIOUS EVALUATIONS check box if yes and provide year

☐		Full Physical Exam	☐		Psychological Evaluations
☐		WPPSI or WISC-R for Intelligence	☐		Speech and Language Evaluations
☐		Genetic Evaluation	☐		Neurological Evaluations
☐		Gastroenterology Evaluations	☐		Other Injuries
☐		Celiac/Gluten Testing	☐		Auditory Evaluation
☐		Allergy Evaluation	☐		Vision Testing
☐		Nutritional Evaluation	☐		Labs (Please provide copies of results)
☐		X-rays or Scans			

HOSPITALIZATIONS/INJURIES/SURGERIES

Date	Describe

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DISEASES/DIAGNOSIS/CONDITIONS *Check appropriate box and provide date of onset for any of these conditions if applicable.*

	Date	GASTROINTESTINAL
☐		Irritable Bowel Syndrome
☐		Inflammatory Bowel Disease
☐		Crohn's
☐		Ulcerative Colitis
☐		GERD (reflux)
☐		Celiac Disease
☐		Chronic Diarrhea
☐		Chronic Constipation
		CARIOVASCULAR
☐		Heart Disease
☐		Elevated Cholesterol
☐		Other
		METABOLIC/ENDOCRINE
☐		Type 1 Diabetes
☐		Type 2 Diabetes
☐		Metabolic Syndrome
☐		Hypothyroidism (low thyroid)
☐		Hyperthyroidism (overactive thyroid)
☐		Weight Gain
☐		Weight Loss
☐		Bulimia
☐		Anorexia
☐		Eating Disorder (Non-specific)
☐		Other
		CANCER
☐		

		NEUROLOGIC/MOOD
☐		Depression
☐		Anxiety
☐		Bipolar Disorder
☐		Schizophrenia
☐		Migraines
☐		Seizures

	Date	GENTIAL AND URINARY SYSTEMS
☐		Urinary Tract Infections
☐		Yeast Infections
		MUSCULOSKELETAL/PAIN
☐		Arthritis
☐		Chronic Pain
☐		Other
		INFLAMMATORY/AUTOIMMUNE
☐		Autoimmune Disease
☐		Poor Immune Function
☐		Food Allergies
☐		Environmental Allergies
☐		Multiple Chemical Sensitivities
☐		Latex Allergy
☐		Repeat or Recurrent Strep Throat
☐		Other
		RESPIRATORY DISEASES
☐		Frequent Ear Infections
☐		Frequent Upper Respiratory Infections
☐		Asthma
☐		Chronic Sinusitis
☐		Bronchitis
☐		Sleep Apnea
☐		Other
		SKIN DISEASES
☐		Eczema
☐		Psoriasis
☐		Acne
☐		Other
		NEUROLOGIC/MOOD
☐		Sensory Integrative Disorder
☐		Autism
☐		Mild Cognitive Impairment
☐		Headaches
☐		ADD/ADHD
☐		Other Neurological Problems

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FAMILY HISTORY

List all psychological and medical conditions that run in the patient's family:

Family Member	Current Conditions	Past Conditions
Mother		
Father		
Siblings		
Other		

Who does the patient live with? _____

Who are the main people who care for your child and what is their occupation?

_____

_____

TRAVEL HISTORY

Has the patient traveled to foreign countries? ☐ Yes ☐ No **Where?** _____

_____

Any wilderness camping? ☐ Yes ☐ No **Where?** _____

_____

Ever had: ☐ Gastroenteritis ☐ Diarrhea **Describe:** _____

_____

DENTAL HISTORY

Fillings?: ☐ Yes ☐ No **What kind?** _____

Other Dental Problems: ☐ Yes ☐ No **If so, please describe:** _____

_____

Regular Dental Visits?: ☐ Yes ☐ No

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MEDICATIONS

CURRENT MEDICATIONS

Medication	Dose	Frequency	Start Date (mo/yr)	Reason for Use

PREVIOUS MEDICATIONS *(Last 10 Years)*

Medication	Dose	Frequency	Start Date (mo/yr)	Reason for Use

NUTRITIONAL SUPPLEMENTS (VITAMINS/MINERALS/HERBS/HOMEOPATHY)

Supplement and Brand	Dose	Frequency	Start Date (mo/yr)	Reason for Use

Have medications or supplements ever caused any unusual side effects or problems: ☐ Yes ☐ No **If so, please describe:** _____

_____

Has the patient had prolonged or regular use of NSAIDS (Advil, Aleve, etc.), Motrin, Aspirin? ☐ Yes ☐ No **If so please describe:** _____

_____

Has the patient had prolonged or regular use of Tylenol? ☐ Yes ☐ No

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Has the patient had prolonged or regular use of Acid Blocking Drugs (Tagamet, Zantac, Prilosec, etc.), Motrin, Aspirin? □ Yes □ No **If so please describe:** _____

_____

Frequent antibiotics > 3 time/year? □ Yes □ No
Long term antibiotics? □ Yes □ No
Use of steroids (prednisone, nasal allergy inhalers) in the past? □ **Yes** □ **No**

VISION AND HEARING

Vision	□ Normal	□ Abnl	□ Not Sure
Hearing	□ Normal	□ Abnl	□ Not Sure

IMMUNIZATIONS

Is your child up to date with immunizations?	□ *Yes* □ *No*
If not, what is your child not immunized for: _____	

EARLY CHILDHOOD ILLNESSES

Number of earaches in the past two years: _____
Number of other infections in the first two years: _____
Number of time your child had antibiotics in the first two years of life: _____
First antibiotic at _____ months.
First illness at _____ months.

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PATIENT BIRTH AND DEVELOPMENTAL HISTORY

Mother's Past Pregnancies

Number of Pregnancies: _____ **Number of Live Births:** _____
Number of Miscarriages: _____

Mother's Pregnancy – *Check box if yes and provide description if applicable*

☐	Infertility drugs used – Specify:	☐	Have c-section because of
☐	Drink alcohol	☐	Have Rhogam, if so how may shots:
☐	Smoke tobacco		How many Rhogam shots when pregnant:
☐	Take prenatal vitamins	☐	Take antibiotics during Labor
☐	Take antibiotics during pregnancy	☐	Gestational Diabetes
☐	Take other drugs Specify:	☐	High blood pressure (pre-eclampsia)
☐	Excessive vomiting, nausea (more than 3 weeks)	☐	High blood pressure/toxemia
☐	Have a viral infection	☐	Have chemical exposure
☐	Have a yeast infection	☐	Father have chemical exposure
☐	Have amalgam fillings put in teeth	☐	Move to a newly built house
☐	Have amalgam filling removed from teeth	☐	House painted indoors
☐	Have bleeding? If so which months?	☐	House exterminated for insects
☐	Have birth problems		

PREGNANCY

Total weight gain during pregnancy: _____ **lbs.**
Total weight loss during pregnancy: _____ **lbs.**
Please describe diet during pregnancy: _____

_____

_____

Please describe labor: _____

_____

_____

PERINATAL

Pregnancy duration: *(Please indicate at what week your baby was born)*
☐ 24 ☐ 25 ☐ 26 ☐ 27 ☐ 28 ☐ 29 ☐ 30 ☐ 31 ☐ 32 ☐ 33 ☐ 34
☐ 35 ☐ 36 ☐ 37 ☐ 38 ☐ 39 ☐ 40 ☐ 41 ☐ 42 ☐ 43 ☐ 44
Very active before birth? ☐ Yes ☐ No
Hospital/Birthing Center? ☐ Yes ☐ No
Needed Newborn Special Care? ☐ Yes ☐ No

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Appeared Healthy? □ Yes □ No
Easily consoled during first month? □ Yes □ No **If no, please describe:** _____

_____

Antibiotics first month? □ Yes □ No **If so, please describe:** _____

_____

Experienced any complications during first month of life? □ Yes □ No If so, please describe: _____

_____

BIRTH WEIGT AND APGAR

Weight at birth: _____ **lbs.** **Apgar score at 1 minute:** _____
Apgar score at 5 minutes: _____

DEVELOPMENTAL HISTORY

Please indicate the approximate age in months for the following milestones:

Sitting Up	months	□ Never		Dry at night	months	□ Never
Crawl	months	□ Never		1st words	months	□ Never
Pulled to stand	months	□ Never		Spoke clearly	months	□ Never
Potty trained	months	□ Never		Lost language	months	□ Never
Walked alone	months	□ Never		Lost eye contact	months	□ Never

Any developmental problems? □ Yes □ No **If so, please describe:** _____

_____

_____

_____

ANYTHING ELSE

Is there anything else that you would like me to know? _____

_____

_____

_____

_____