Better Gut Better Health
Child Intake Questionnaire

My ability to draw effective conclusions about your present state of health and how to improve it depends, to a significant extent, on your ability to respond thoughtfully and accurately to both these written questions and those posed by the clinician during consultations. Health issues are usually influenced by many factors. Accurately assessing all the factors and comprehensively managing them is the best way to deal with these health challenges. Your careful consideration of each of the following questions will enhance our efficacy and will provide for more effective use of your scheduled consult time. If possible, please fax this back to me at (847) 232- 9810. The answers to these questions will help us identify underlying causes of illness and will also assist me to formulate an appropriate plan of action. If you have questions when filling this out please call (630) 853-8891.

Child's name:____ Age:______ Birth date:______________

Gender: _____________ Height or Length:________________ Weight: ___________________________

Place of Birth: ____

Please check child's appropriate box:

□ African American □ Latino □ Caucasian □ Asian □ Native American □ Mediterranean

□ Northern European □ Other: ____

Mother's Name (or Guardian):____

Address:__________________________________ City:__________________ State:_____ Zip:________

E-mail Address: ______________________________ Fax Number : (_____) __________- ___________

Home Phone: (____) _______- ________ Work: (____) ______- ________ Cell: (____) _____-________

Age: ________ Blood Type: _________ Occupation: ____

Statement of Heath: ____

Father's Name (or Guardian): ____

Address:__________________________________ City:__________________ State:_____ Zip:________

E-mail Address: ______________________________ Fax Number : (_____) __________- ___________

Home Phone: (____) _______- ________ Work: (____) ______- ________ Cell: (____) _____-________

Age: ________ Blood Type: _________ Occupation: ____

Statement of Health: ____

Please rank child's current problems by priority and fill in the other boxes as completely as possible:

DESCRIBE PROBLEM	MILD/MODERATE/SEVERE	TREATMENT APPROACH	SUCCESS
Example: Post Nasal Drip	Moderate	Elimination Diet	Moderate

Please check any other problems:

□ Speech
□ Behavior
□ Short attention span
□ Academic problems
□ Bed wetting
□ Mood swings
□ Immaturity
□ Sweet tooth
□ Craves junk food
□ Fear, Anxiety
□ Allergies
□ Poor peer relations
□ Learning disability
□ Often tired
□ Excessive fluid intake
□ Poor coordination
□ Hyperactivity
□ Other: ______________________________

PRECONCEPTION INFORMATION:

Were any medications taken 3 years prior to pregnancy by mother or father? □ Yes □ No

If yes, please explain: ______________________________

____

Were there any serious illnesses prior to pregnancy? □ Yes □ No

If yes, please explain: ______________________________

____

Did mother or father suffer a nervous breakdown or serious emotional upset prior to pregnancy or since?

□ Yes □ No

If yes, please explain: ______________________________

____

PRENATAL INFORMATION:

Apgar rating (if known): ____________

Were forceps used during birth? □ Yes □ No

Was vacuum extraction used during birth? □ Yes □ No

Did mother or baby have thrush, yeast, or candida infection? □ Yes □ No

Please explain anything unusual about the birth: ______________________________

____

____

____

____

POST NATAL DEVELOPMENT:

Did baby have early feeding problems? □ Yes □ No

If yes, please describe: ____

____

Did child hit developmental milestones at appropriate times? (i.e. speech)? □ Yes □ No

If no, please explain: ____

____

Was baby colicky? □ Yes □ No

If yes, please explain: ____

____

At what age did baby: Hold head up? ________ Turn over both ways? ________ Sit alone? ________

Did/ does baby bang head frequently? □ Yes □ No

If yes, please explain: ____

MATERNAL HISTORY:

Please check the appropriate box regarding mother's health history.

Did mother have any:	**1st Trimester** (conception to 3rd mo.)		**2nd Trimester** (4th – 7th mo.)		**3rd Trimester** (7th mo. to birth)	
	YES	**NO**	**YES**	**NO**	**YES**	**NO**
Medications						
X-Rays						
Infectious Diseases						
High Blood Pressure						
Severe Nausea/ Vomiting						
Serious Emotional Upsets						
Injuries						
Hospitalizations						
Abnormal Weight Gain						
Hemorrhage						
Spotting						
Swelling of feet						
Exposure to Viral Diseases						
Albumin in urine						
Toxemia						
Other Disorders						

Please explain any "yes" answers: ____

____

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____

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____

____

PERINATAL INFORMATION:

Where was child born? (hospital, home, etc.) ____________________

Birth Weight: ____________________ Was baby born pre-mature? □ Yes □ No

Length of labor: ____________________ Was labor difficult? □ Yes □ No

Was labor induced? □ Yes □ No

If yes, please describe and provide reason: ____________________

____

Was labor delayed? □ Yes □ No

If yes, please describe and provide reason: ____________________

____

Was this a Cesarean birth? □ Yes □ No

If yes, please provide details: ____________________

____

Was baby a twin? □ Yes □ No □ Identical □ Fraternal □ Born first □ Born second

Did baby require more than routine oxygen at birth? □ Yes □ No

If yes, please describe: ____________________

____

Was baby discolored at birth? □ Yes □ No □ Blue □ Jaundice □ Other: ____________________

Were there any other observable abnormalities of baby at birth? □ Yes □ No

If yes, please describe: ____________________

____

Did baby need treatments immediately after birth? (i.e. tube feedings, surgery) □ Yes □ No

If yes, please describe: ____________________

____

Did baby have sucking problems at birth or since? □ Yes □ No

If yes, please explain: ____________________

____

POST NATAL INFORMATION:

Did baby have early feeding problems? □ Yes □ No

If yes, please explain: ____________________

____

At what age was child toilet trained? ____________Was difficulty encountered? □ Yes □ No

If yes, please explain: ____________________

____

MEDICAL HISTORY:

Give approximate age child had any of the following diseases:

_________ Chicken Pox
_________ Roseola
_________ Influenza (flu)
_________ Rheumatic fever
_________ Tuberculosis
_________ Nervousness
_________ Fainting spells
_________ Other

_________ Measles (Red)
_________ Mumps
_________ Mononucleosis
_________ Hepatitis
_________ Encephalitis
_________ Nervous breakdown
_________ Heart palpitations

_________ Measles (German)
_________ Whooping cough
_________ Scarlet fever
_________ Pneumonia
_________ Epilepsy
_________ Emotional problems
_________ Shortness of breath

Please describe any unusual complications of those listed above: ________________________________

____

____

____

____

Has child ever had a high temperature? □ Yes □ No

If yes, how high? ______________________ Please explain: ____________________________________

____

Has child ever had injuries? □ Yes □ No

If yes, state location and results: ____

____

Has child ever had any operations? □ Yes □ No

If yes, state type and results: ____

____

Please list family disease history (i.e. cancer, diabetes, heart disease, epilepsy, etc)

Mother's side: ____

____

____

Father's side: ____

____

____

Please check any *current* medical issues:

	Illness	**Age of onset**	**Comments**
	Anemia (type)		
	Arthritis		
	Asthma		
	Bronchitis		
	Cancer		
	Crohn's Disease or Ulcerative Colitis		
	Diabetes		
	Epilepsy, Convulsions, or Seizures		
	Heart murmur		
	Other (please list):		

EDUCATION & SOCIAL HISTORY:

Is your child presently enrolled in school? □ Yes □ No

If yes, please describe type of school (public, private, special, etc.) and school situation: ______________

____

____

Has child ever been held back a grade? □ Yes □ No

If yes, pleas explain: ____

Is child an over or under-achiever? □ Yes □ No

If yes, please explain: ____

____

What are child's hobbies and leisure activities? ____

____

____

Has child ever lived outside of the United States? □ Yes □ No

If yes, where and when? ____

Has the child or family recently experienced any major life changes? □ Yes □ No

If yes, please explain: ____

____

Has child experienced any major stress or losses in life? □ Yes □ No

If yes, please explain: ____

____

Please check current parental situation:

□ Married □ Together □ Separated □ Divorced □ Single parent household □ Other (specify)

Comments: ____

____

Who does the child live with? Please describe: ____

____

____

Please list siblings in order of birth (include patient):

Name	Gender	Age	Health Status	Adopted?

STOMACH & INTESTINAL:

Does child have any *current:*

Stomach or Intestinal disorders? □ Yes □ No

If yes, please explain: ______________________________

____

Please check the appropriate box below with information about child's recent bowel movements:

Frequency:

□ More than 3 times per day □ 2-3 times per day □ 1 time per day □ 4-6 times per week

□ 2-3 times per week □ 2-3 times per week □ 1 time or less per week

Consistency:

□ Soft and well formed □ Often float □ Difficult to pass □ Diarrhea

□ Thin, long or narrow □ Small and hard □ Loose, but not watery

□ Alternating between hard and loose/watery

Color:

□ Dark brown □ Medium brown □ Very dark brown □ Very dark or black

□ Greenish □ Blood is visible □ Varies a lot □ Yellow, light brown

□ Greasy, shiny appearance

Does child experience anal itching? □ Yes □ No

SKIN & SKELETON:

Does child have any *current:*

Skin disorders? (i.e. eczema, excessive dryness, burns) □ Yes □ No

I If yes, please explain: ______________________________

____

Athlete's foot? □ Yes □ No

I If yes, please explain: ______________________________

____

Bone or joint disorders? (i.e.arhritis) □ Yes □ No

If yes, please explain: ______________________________

____

ENDOCRINE:

Does child have any *current:*

Issues being over or underweight: □ Yes □ No

I If yes, please explain: ______________________________

____

Diabetes? ☐ Yes ☐ No

If yes, please explain and provide age of diagnosis: ______________________________

____

High or low blood sugar? ☐ Yes ☐ No

I If yes, please explain: ____

____

Thyroid imbalance? ☐ Yes ☐ No

I If yes, please explain: ____

____

Menstrual disorder? ☐ Yes ☐ No ☐ N/A

I If yes, please explain: ____

____

Late, early, or abnormal sexual development? ☐ Yes ☐ No

If yes, please explain: ____

____

HEART AND LUNGS:

Does child have a *current:*

Chronic cough? ☐ Yes ☐ No

If yes, please explain: ____

____

Bronchial disorder? ☐ Yes ☐ No

If yes, please explain: ____

____

Heart disorder? ☐ Yes ☐ No

If yes, please explain: ____

____

Heart murmur? ☐ Yes ☐ No

If yes, please explain: ____

____

Lung disorder? ☐ Yes ☐ No

If yes, please explain: ____

____

CENTRAL NERVOUS SYSTEM:

Does child have any *current:*

Reoccurring headaches or dizziness? □ Yes □ No

If yes, please explain: ______________________________

____

Coordination problems? □ Yes □ No

If yes, please explain: ______________________________

____

Head or brain injury? □ Yes □ No

If yes, please explain: ______________________________

____

Nerve or muscle disorders? □ Yes □ No

If yes, please explain: ______________________________

____

Seizure disorders? □ Yes □ No

If yes, please explain: ______________________________

____

SPEECH AND AUDITORY:

Does child have speech problems now? □ Yes □ No

If yes, please explain: ______________________________

____

Does child have difficulty with hearing? □ Yes □ No

If yes, please explain: ______________________________

____

Is child in speech therapy? □ Yes □ No

If yes, please explain: ______________________________

____

Is child exceptional in music ability? □ Yes □ No

If yes, please explain: ______________________________

____

EARS, NOSE, AND THROAT:

Does child have any *current:*

Ear disorders? □ Yes □ No

If yes, please explain: ______________________________

Nose disorders? ◻ Yes ◻ No

If yes, please explain: ____________________

____________________-

Throat disorders? ◻ Yes ◻ No

If yes, please explain: ____________________

____

DENTAL HISTORY

Does child have amalgam (silver, black, or grey) fillings? ◻ Yes ◻ No

If yes, how many? ____________________

Has child ever had fillings replaced? ◻ Yes ◻ No

If yes, how many? __________ When?__________ With what material? __________

Has child had any root canals? ◻ Yes ◻ No

If yes, how many? ____________________

Has child had any cavities in the last 2 years? ◻ Yes ◻ No

If yes, how many? ____________________

Do child's gums ever bleed? ◻ Yes ◻ No

If yes, how often? ____________________

Does child grind their teeth? ◻ Yes ◻ No

If yes, how often? ____________________

ALLERGY & TOXIC POTENTIAL:

Does child have any:

Food allergies or intolerances? ◻ Yes ◻ No

I yes, please list: ____________________

____

Drug/medication allergies? ◻ Yes ◻ No

I yes, please list: ____________________

____

Environmental allergies? ◻ Yes ◻ No

I yes, please list: ____________________

____

Does child have any pets or farm animals? ◻ Yes ◻ No

If yes, what kind and where do they live (indoor/outdoor)? : ____________________

____

Do odors such as perfumes, cleaning solutions, smoke, etc affect child? □ Yes □ No

If yes, please explain: ____

____

To your knowledge, has child been exposed to toxic metals? □ Yes □ No

If yes: □ Lead □ Cadmium □ Arsenic □ Mercury □ Aluminum □ Asbestos

To your knowledge, has child been exposed to any of the following:

□ Solvents □ Paints □ Pesticides □ Petrochemicals □ Coal □ Hydrocarbons □ Mold

□ Other (specify): ______________________ □ None

Have past activities/hobbies exposed child to glues, paints, or dyes? □ Yes □ No

If yes, please explain: ____

____

Is the child exposed to regular lawn care service? □ Yes □ No

If yes, how often? ____

Is bug spray (outside) or insecticides (indoors) used on a regular basis? □ Yes □ No

If yes, how often? ____

Is the child now or was ever exposed to second hand smoke? □ Yes □ No

If yes, when? ____

BEHAVIOR AND EMOTIONAL CHARACTERISTICS

Does child seek company of younger children? □ Yes □ No

If yes, please explain: ____

____

Does child seek company of older children? □ Yes □ No

If yes, please explain: ____

____

Does child annoy or antagonize other children? □ Yes □ No

If yes, please explain: ____

____

Does child bite nails? □ Yes □ No

If yes, please explain: ____

____

Is child afraid of the dark? □ Yes □ No

If yes, please explain: ____

____

Is child very shy? □ Yes □ No

If yes, please explain: ____

Is child unusually active? □ Yes □ No

If yes, please explain: ______________________________

____

Is child unusually distractible? □ Yes □ No

If yes, please explain: ______________________________

____

Is child unusually tired? □ Yes □ No

If yes, please explain: ______________________________

____

Is child unusually destructive? □ Yes □ No

If yes, please explain: ______________________________

____

Is child ever considered dangerous? □ Yes □ No

If yes, please explain: ______________________________

____

Does child have poor social adjustment to family, classmates, and/or teachers? □ Yes □ No

If yes, please explain: ______________________________

____

Is child's behavior changeable? One hour pleasant and the next disagreeable? □ Yes □ No

If yes, please explain: ______________________________

____

Has a change of surroundings ever made a distinct change in behavior? □ Yes □ No

If yes, please explain: ______________________________

____

LIFESTYLE INFORMATION:

Does child need more sleep than most? □ Yes □ No

Does child have trouble getting to sleep? □ Yes □ No

Does child have trouble staying asleep? □ Yes □ No

If yes, please describe: ______________________________

____

Does child ever need to take a sleep aid? □ Yes □ No

If yes, which one(s)? ______________________________

How often? ______________________________

What is child's usual bed time? ____________ Wake time? ____________

Check off typical bedtime activities:

□ Watch televison □ Read a book □ Listen to music □ Bed time snack □ Bathe/shower

□ Other (please specify): ______________________________

Does child exercise regularly? □ Yes □ No

If yes, please specify how many times per week: □ Once □ 2 times □ 3 times □ 4 or more times

Time length per session: □ < 15 minutes □ 15-30 minutes □ 30-45 minutes □ > 45 minutes

What type of activities is child involved in (i.e. dance, soccer, gymnastics, tennis, etc)? ______________

____

____

____

Does child get sun exposure? □ Yes □ No

If yes, how much on a weekly or daily basis? ______________________________

Does child wear sun block? □ Yes □ No

If yes, what percent of the time? ______________________________

MEDICATIONS & SUPPLEMENTS

Has child ever been on medication longer than 2 weeks? □ Yes □ No

If yes, please explain: ______________________________

____

Please list any medications child is taking on a *daily/regular* basis:

Medication Name	Purpose	Dosage	Start Date

Please list all vitamins, minerals, and other nutritional supplements child is taking on a *daily/regular* basis. Indicate dosage (mg or IU), and form (i.e. calcium carbonate vs. calcium lactate).

******PLEASE BRING BOTTLES TO APPOINTMENT******

Vitamin/Mineral/Supplement	Brand Name	Dosage	Start Date

Does child take over the counter medications on an *occasional* basis (i.e. Tylenol, cold medicine, etc)?

□ Yes □ No If yes, which ones and how often? ____

____

Has child ever been on antibiotics for a prolonged period of time? □ Yes □ No

If yes, please explain:____

____

How many times has child taken oral steroids (i.e Prendisone)?

□ Less than 5 times □ Greater than 5 times □ Greater than 10 times

Does child swallow pills? □ Yes □ No

Please describe any difficulties encountered when giving medication and/or vitamins: _______________

____

____

____

DIETARY HABITS:

Is the child currently on a special diet (i.e. vegetarian, Kosher, etc.)? □ Yes □ No

If yes, please explain: ____

____

Does child avoid certain foods? □ Yes □ No

If yes, which foods and why? ____

Does child crave certain foods? □ Yes □ No

If yes, which foods? ____

Does child enjoy eating? □ Yes □ No

Comments: ____

____

Does child currently or typically have symptoms (belching, fatigue, bloating, etc) immediately after eating?

□ Yes □ No

If yes, please explain: ____

____

Are these associated with any particular foods (i.e. milk: causes gas, diarrhea): _____________________

____

____

Does child have delayed symptoms after eating certain foods? (Delayed symptoms may not be evident for 24 hours or more after eating) □ Yes □ No

If yes, please explain: ____

____

Does skipping meals affect symptoms? □ Yes □ No

If yes, please explain: ____

____

What is child's usual:

Breakfast time: __________ Lunch time: __________ Dinner time: __________ Snacks: _________________

Place a mark after the food/drink that applies to a typical day of child's current diet:

Breakfast		**Lunch**		**Dinner**	
None		None		None	
Cereal		Eat in cafeteria		Pasta	
Wheat bran		Eat in restaurant		Potato	
Oatmeal		Leftovers		Brown rice	
Toast		Meat sandwich		White rice	
Bagel		Fish sandwich		Beans (legumes)	
Sweet roll		Lettuce (on sandwich)		Fish	
Donut		Tomato		Red meat	
Eggs		Salad		Poultry	
Bacon/sausage		Salad dressing		Salad	
Fruit		Soup		Salad dressing	
Yogurt		Fruit		Green vegetables	
Milk		Yogurt		Carrots	
Juice		Milk		Yellow vegetables	
Water		Juice		Milk	
Butter		Water		Juice	
Margarine		Regular soda		Water	
Sugar		Diet soda		Regular soda	
Sweetener		Butter		Diet soda	
Leftovers		Margarine		Butter	
Other:		Mayonnaise		Margarine	
Other:		Sugar		Sugar	
Other:		Sweetener		Sweetener	
Other:		Other:		Other:	
		Other:		Other:	
		Other:		Other:	
		Other:		Other:	

If child could plan their day, what would it be like?

Time of awakening: ________________________ Breakfast: ______________________________________

Activity: __________________________________ Snack: ____

Activity: __________________________________ Lunch: ____

Activity: __________________________________ Snack: ____

Activity: __________________________________ Dinner: ____

Activity: __________________________________ Snack: ____

Bedtime: _________________________________

COMMENT SECTION:

Please list anything else you think we should know: ____

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