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### QUESTIONNAIRE FOR INFANTS AND CHILDREN

Name \_\_\_\_\_ M/F \_\_\_\_\_ DOB \_\_\_\_\_

Parent's Name(s) \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_ Email \_\_\_\_\_

List the primary physicians who care for your child's health:

Why are you seeking nutritional health services for your child:

History of the mother and child- pre-natal/newborn/infant:



Did you have difficulty getting pregnant? yes \_\_\_\_\_ no \_\_\_\_\_

Did you use any fertility treatments to conceive? yes \_\_\_\_\_ no \_\_\_\_\_

Did you experience any nausea or morning sickness, water retention, toxemia, back ache, kidney or yeast infections, or other symptoms during pregnancy? yes \_\_\_\_\_ no \_\_\_\_\_ Please list \_\_\_\_\_

Did you take pre-natal or other vitamins during pregnancy? Please list \_\_\_\_\_

Was your child born vaginally \_\_\_\_\_ or by C-section \_\_\_\_\_?

Was your child born on time \_\_\_\_\_ early \_\_\_\_\_ late \_\_\_\_\_?

Any complications of birth? \_\_\_\_\_

As a newborn, did your child have jaundice, rashes, difficulty sleeping or eating?

\_\_\_\_\_ Did you breastfeed your child? yes \_\_\_\_\_ no \_\_\_\_\_ If yes, how long? \_\_\_\_\_

At what age did you introduce solid foods? \_\_\_\_\_

Has your child been vaccinated? yes \_\_\_\_\_ no \_\_\_\_\_ did your child experience any reactions after vaccination (fever, irritability, fatigue, rashes, etc)? yes \_\_\_\_\_ no \_\_\_\_\_

Has your child had any surgeries? yes \_\_\_\_\_ no \_\_\_\_\_ if yes, please describe:

Does your child take any vitamins, herbs, or homeopathic remedies? yes \_\_\_\_\_ no \_\_\_\_\_ If yes, please list:

Does your child take any medications? Describe their purpose and frequency of use.



Has your child taken antibiotics? yes \_\_\_\_\_ no \_\_\_\_\_ If yes, approximately for how long and how many times?

Give a brief description of your child's current, average daily diet:

What types of beverages does your child consume? How often?

Does your child have an aversion to certain foods? Please list:

What are your child's favorite foods?



Has your child now or ever had difficulty gaining or losing weight?

How often does your child have a bowel movement? \_\_\_\_\_ Describe the average consistency of the stool if the child still uses a diaper, or describe the form of the stool if the child is potty trained \_\_\_\_\_

**Symptom Questionnaire:**

Has your child now, or in the past, experienced any of the following? Put a check mark next to those symptoms that apply.

allergies \_\_\_\_\_ bedwetting \_\_\_\_\_ diaper rash \_\_\_\_\_ runny nose \_\_\_\_\_ asthma \_\_\_\_\_  
colic \_\_\_\_\_ cries easily \_\_\_\_\_ headaches \_\_\_\_\_ gas \_\_\_\_\_  
ear infections \_\_\_\_\_ sore throats \_\_\_\_\_ constipation \_\_\_\_\_ diarrhea \_\_\_\_\_  
nosebleeds \_\_\_\_\_ fear of the dark \_\_\_\_\_ hyperactivity \_\_\_\_\_ restless sleeper \_\_\_\_\_  
bad dreams \_\_\_\_\_ other \_\_\_\_\_

Please use the following space to describe any other information about your child that would be helpful which has not already been covered:



I hereby acknowledge that the above information is correct to the best of my knowledge:

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(Parent's name)

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(Parent's signature)