

Personal Information: Please check any problems your child currently or has ever had:

- Thumb Sucking Yes No
- Diarrhea Yes No
- Irritable/temper tantrums Yes No
- Nightmares/sleep problems Yes No
- Feeding/eating problems Yes No
- # of meals each day _____
- # of sacks each day _____
- Does your child take vitamins, fluoride, iron, or other supplements? Yes No
- Has your child ever eaten dirt, paint, or plaster? Yes No
- Does your child get along well with other children? Yes No
- Is your child doing well in school? Yes No
- Did the mother use any cigarettes, alcohol, drugs, or medications during pregnancy? Yes No
- Toilet training Problems Yes No
- Dental problems Yes No
- Bed Wetting Yes No
- Eye Problems Yes No
- Speech Problems Yes No
- Hearing Problems Yes No
- Emotional Problems Yes No
- Discipline Problems Yes No
- Developmental Problems Yes No
- Alcohol/drug abuse Yes No
- Child's weight at birth _____
- Delivery C-Section Vaginal
- Were forceps or vacuum extraction used during delivery? Yes No
- Was your child born more than two weeks early or late? Yes No
- Was/Is the child breastfed? Yes No
- Age discontinued _____

Has your child ever had any of the following health issues:

- Mumps, Measles Yes No
- Chicken Pox Yes No
- Eczema/Skin Problems Yes No
- Pneumonia Yes No
- Asthma/Wheezing Yes No
- Cancer Yes No
- Hepatitis Yes No
- HIV/AIDS Yes No
- Abnormal Bleeding Yes No
- Hemophilia Yes No
- Allergies Yes No
- Frequent colds or sore throats Yes No
- Emotional Disorders/Suicide Attempt Yes No
- Croup Yes No
- TB/Lung Disease Yes No
- High Blood Pressure Yes No
- Kidney/Bladder Problems Yes No
- Sexually Transmitted Disease Yes No
- High Cholesterol Yes No
- Handicaps/Disabilities Yes No
- Diabetes Yes No
- Rheumatic Fever Yes No
- Congenital Heart Defect Yes No
- Heart Murmur Yes No
- Convulsions/Epilepsy Yes No
- Broken Bones Yes No
- Major Trauma, falls or car accidents Yes No

Please explain any medical issues that your child has: _____

Please list any major illnesses, injuries, falls, auto accidents, or surgeries (Including dates): _____

Please list any medications or supplements your child takes: _____
