TRIPLE H CLINIC
Holistic Health and Healing
of Winding Waters

Phone 541-426-4502 Fax 541-426-6403 Holistic@windingwaters.org

Pediatric & Teens New Patient Questionnaire Part I: ENT-Allergy

*Please indicate the severity of symptoms by **circling or highlighting the number** that applies:*

0 = None ☺ 1 = Not so bad 2 = Moderate 😐 3 = Pretty bad 4 = Severe ☹

Nose symptoms

	☺	😐	☹
Sneezing spells	0	1 2	3 4
Itchy nose	0	1 2	3 4
Rub nose a lot	0	1 2	3 4
Stuffy nose	0	1 2	3 4
Runny, watery	0	1 2	3 4
Post-nasal drip	0	1 2	3 4
Nosebleeds	0	1 2	3 4
Can't smell	0	1 2	3 4
Nasal Polyps	0	1 2	3 4
Snoring	0	1 2	3 4
Sinus infections	0	1 2	3 4
"Sinus"	0	1 2	3 4

Throat symptoms

Clear often	0	1 2	3 4
Sore with fever	0	1 2	3 4
Sore, no fever	0	1 2	3 4
Thick mucus	0	1 2	3 4
Lump in throat	0	1 2	3 4
Hoarseness	0	1 2	3 4
Itching	0	1 2	3 4

Ear symptoms

Full, pressure	0	1 2	3 4
Pops, crackles	0	1 2	3 4
Itching in canal	0	1 2	3 4
Fluid in ears	0	1 2	3 4
Freq infections	0	1 2	3 4
Tubes inserted	0	1 2	3 4
Red ears /lobes	0	1 2	3 4
Ringing	0	1 2	3 4
Dizziness	0	1 2	3 4
Hearing loss	0	1 2	3 4

Eye symptoms

Itching	0	1 2	3 4
Burning	0	1 2	3 4
Red	0	1 2	3 4
Watery	0	1 2	3 4
Puffy	0	1 2	3 4
Light sensitive	0	1 2	3 4
Dark circles	0	1 2	3 4

Chest symptoms

Cough	0	1 2	3 4
Wheezing	0	1 2	3 4
Asthma	0	1 2	3 4
Chest tightness	0	1 2	3 4
Freq bronchitis	0	1 2	3 4
Freq pneumonia	0	1 2	3 4
Congestion	0	1 2	3 4

Skin symptoms

	☺	😐	☹
Itchy rash	0	1 2	3 4
Itchy, no rash	0	1 2	3 4
Hives	0	1 2	3 4
Eczema	0	1 2	3 4
Cracked nails	0	1 2	3 4
Easy bruising	0	1 2	3 4
Puffy hands /feet	0	1 2	3 4
Seborrhea /dandruff	0	1 2	3 4
Diaper rash	0	1 2	3 4
Colorless rash (Esp. cheeks, arms)	0	1 2	3 4

Gastrointestinal

Swollen /sore lips	0	1 2	3 4
Drooling	0	1 2	3 4
Canker sores	0	1 2	3 4
Mottled tongue	0	1 2	3 4
Itchy roof of the mouth	0	1 2	3 4
Bad breath	0	1 2	3 4
Belching	0	1 2	3 4
Nausea	0	1 2	3 4
Reflux, vomit	0	1 2	3 4
Bellyaches /colic	0	1 2	3 4
Bloated, gas	0	1 2	3 4
Diarrhea	0	1 2	3 4
Constipation	0	1 2	3 4
Itchy bottom	0	1 2	3 4
Soil pants, leaks Stool	0	1 2	3 4

Nervous system

Irritable	0	1 2	3 4
Restless/Hyper	0	1 2	3 4
Attention deficit	0	1 2	3 4
Behavior probs	0	1 2	3 4
Learning disability	0	1 2	3 4
Listless, tired	0	1 2	3 4
Chronic fatigue	0	1 2	3 4
Cries often	0	1 2	3 4
Sad/depressed	0	1 2	3 4
Clumsy	0	1 2	3 4
Sleeps poorly	0	1 2	3 4
Nightmares	0	1 2	3 4
Spaced out	0	1 2	3 4
Seizures	0	1 2	3 4

Urinary system

	☺	😐	☹
Bed-wetting	0	1 2	3 4
Wet pants in the day	0	1 2	3 4
Up to urinate at night	0	1 2	3 4
Pain on urination	0	1 2	3 4
Burning	0	1 2	3 4
Urgency	0	1 2	3 4
Bloody urine	0	1 2	3 4
Symptoms change with seasons	0	1 2	3 4

Miscellaneous

Headaches	0	1 2	3 4
Migraines	0	1 2	3 4
Neck/backaches	0	1 2	3 4
Joint aches	0	1 2	3 4
Leg cramps	0	1 2	3 4
Xs perspiration	0	1 2	3 4
Freq. Infections	0	1 2	3 4
Vaginal Irritation	0	1 2	3 4
Irregular Heartbeat	0	1 2	3 4
Weakness	0	1 2	3 4

Timing of symptoms:

(Check all that apply)

( ) January - February
( ) March - April
( ) May – June
( ) August - September
( ) October - November
( ) All Year
( ) Worst on waking

Name: _____ Date: _____

( ) Worst at bedtime

Are symptoms worse:
(Check all that apply)

( ) Inside your home
( ) At school (or daycare)
( ) In the city
( ) In the country
( ) Mowing grass
( ) Raking leaves
( ) Dig in garden
( ) Walk in woods
( ) Play in barn
( ) Play in basement

Do weather changes make child feel worse?

( ) Cold weather
( ) Dry – breezy weather
( ) Damp weather
( ) Hot – humid
( ) Temperature changes
( ) Before or just after rain

Pets in the home:

( ) Cat
( ) Dog
( ) Bird
( ) Hamster/Gerbil/rodent
( ) Rabbit

Other animal exposure

( ) Horse
( ) Cattle
( ) Other: _____

Known allergies (list):

Home Environment:

Heating:
( ) Electric
( ) Gas heat
( ) Oil heat
( ) Propane tank heat
( ) Wood heat
( ) Other:

Air conditioning:
( ) Central air
( ) Window units

Other factors:
( ) Air filters
( ) Dehumidifier
( ) Humidifier

Other exposures:
( ) Feather pillow
( ) Down comforter
( ) Allergen-proof cases
- cover mattress & pillow
( ) Cigarette smoke

General:

( ) Family history of allergies
( ) Has child been treated for allergies?
( ) Exposed to cigarette smoke? (anywhere)
( ) Sensitive to chemicals?
(Please circle any that apply)

perfumes
detergents
oven cleaner
bug spray
gas fumes
fingernail polish
- Other (please list):

Do chemicals cause child:
( ) Moderate to Severe trouble
( ) Mild symptoms
( ) No problem.

Part II: Food and Yeast Allergy Questions:

(Modified from Crook).

History:

In the two years before your child was born, did Mother have (check all that apply):

( ) Chronic vaginitis
( ) Irregular menses
( ) Premenstrual tension- PMS
( ) Chronic fatigue
( ) Chronic headaches
( ) Depression
( ) Digestive disorders
( ) "Feeling bad all over"

Was your child born:
( ) On time
( ) Prematurely
- if so, how early?
_____wks/mos

When a newborn, was your child fed by:

( ) Breast
( ) Bottle; formula (please circle):
Milk-based
Soy-based

During infancy, did your child have colic and irritability for over three months?

( ) No ( ) Yes

Did your child have cycles of crying for "no reason?"

( ) No ( ) Yes

Did you need to change formula for any reason?

( ) No ( ) Yes

At what age did your child start sleeping through the entire night?
_____mos/yrs
At what age did your child start eating "solid" food?
_____mos

Did your child have ear infections frequently?

( ) No ( ) Yes
If "yes," at what age?

Has your child had too many sinus, chest or other respiratory infections?

( ) No ( ) Yes
If "yes," at what age?
_____

Has your child been diagnosed with or given treatment for asthma?

( ) No ( ) Yes

Did your child have diaper rashes during infancy?

( ) Mild, no big deal
( ) Bad, persistent - recurring

Has your child had eczema or other skin condition that needed medical attention?

( ) No ( ) Yes
If "yes," where?

Has child taken "broad spectrum" antibiotics for infections (ear, respiratory, urinary, or other) for 2 months or 4 times in 1 year?

( ) No ( ) Yes

Has your child taken eight or more courses of antibiotics
Includes Keflex, Ampicillin, Amoxicillin, Ceclor, Bactrim, Septra, Ceftin, Cefzil, Cipro, Levaquin, Avelox, Tequin, Zithromax, and more
during the past three years?

( ) Yes ( ) No
Has child been given oral or injected steroid drugs (Cortisone, Prednisone, Medrol, Decadron) even one time?

( ) No
( ) More than 2 weeks.
( ) For 2 weeks or less.

Are your child's symptoms worse on damp days or in damp or moldy places?

( ) No ( ) Yes

Has your child had Thrush?

( ) No
( ) Mild, no big deal
( ) Bad, persistent - recurring

Has child had athlete's foot, ringworm, "jock itch" or other fungus problems of skin, ears or nails?

( ) No
( ) Yes, severe - persistent
( ) Yes, mild or moderate

Does your child crave:

( ) Sugar
( ) Bread
( ) Alcoholic drinks

List any other foods your child craves:

List any foods to which your child is allergic:

List any foods child dislikes or foods that disagree with child:

Symptoms ("major"):
Please circle all that apply.

	☺ 0	😐 1 2 3	☹ 4
Fatigue-lethargy			
Feels drained			
Poor memory			
Feel spacey, unreal			
Numbness			
Burning			
Tingling			
Headaches			
Muscle aches			
Muscle weakness			
Joint pain, swelling			
Abdominal pain - "bellyaches"			
Hemorrhoids			
Constipation			
Diarrhea			
Bloating, belching, intestinal gas			
Anxiety attacks			
Cold hands, feet or chilliness			
Shaky or irritable when hungry			
Antisocial			
Angry, fights			
Crying			

Symptoms ("minor"):

	☺ 0	😐 1 2 3	☹ 4
Drowsiness			
Irritability or jitteriness			
Clumsiness, lack of coordination			
Unable to concentrate			
Frequent mood swings			
Can't sleep through the night			
Bruise easily			
Skin rashes or chronic itching			
Eczema, psoriasis			
Hives			
Food allergy, sensitivity or intolerance			
Allergic to 2 or more drugs			
Indigestion or Heartburn			
Mucus in stool			
Rectal itching			
Dry mouth or throat			
Blisters in mouth			
Blisters in throat			
Bad breath			
Odor- feet, body or hair even after washing			
Nose congestion or postnasal drip			
Nose itches			
Sore throat, lump in throat			
Hoarseness, loss of voice			
Cough or recurrent bronchitis			
Pain, tightness in throat			
Wheezing, shortness of breath			
Urinary frequency			
Burning urination			
Spots before eyes or vision trouble			
Eyes burn, tears			
Ear infections, fluid in ears			
Ear pain, hearing loss			
Dizziness, loss of balance			
Ear surgery: tubes			

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Part III: Hyperkinesis
Modified Connor's Quest.

Circle all that apply to your child:

	None ☺	😐	Bad! ☹
Excitable, Impulsive	0	1	2 3
Difficulty with learning	0	1	2 3
Restless in a "squirmy" sense	0	1	2 3
Restless, always up and on the go	0	1	2 3
Denies mistakes or blames others	0	1	2 3
Fails to finish things	0	1	2 3
Childish or immature (demands help when not necessary, clings or needs constant reassurance	0	1	2 3
Attention span is short; easily distracted	0	1	2 3
Mood changes quickly and dramatically	0	1	2 3
Easily frustrated in efforts	0	1	2 3

Total: _____/ 30.

Part IV: Thyroid

History: Family

Has anyone in child's family had thyroid trouble of any kind?
(please circle)

- Mother/ Father
- Sister/ Brother
- Grandmother/ Grandfather
- Daughter/ Son
- Aunt/ Uncle
- Niece/ Nephew

If so, what type of trouble?
(circle if you know)

- Low thyroid/ high thyroid
- Nodular goiter
- Thyroiditis
- Cysts
- Benign tumor or mass
- Cancer

History, personal:

Has a doctor ever diagnosed child with thyroid trouble?
(Please circle)

- Yes/ No

If "yes," what kind?

- Low thyroid/ high thyroid
- Nodular goiter
- Thyroiditis
- Cysts
- Benign tumor or mass
- Cancer

How was the diagnosis made?

- Physical exam
- Body temperatures
- Blood test
- Needle biopsy
- Scan
- Operation
- Other:

How was child treated?

- No treatment
- Pills
- Radioactive iodine
- Operation
- Other:

Is child taking thyroid pills?
If so, please fill in the details:

Name of medicine:

_____

Strength of pills (mg, mcg, grains):

_____

Part IV, Thyroid *cont.*

Dose of thyroid pill taken:
How many pills at a time:

_____

How many times a day:

_____

What time of day:

_____

How long has child used the thyroid medication?

_____years

Has the medication been changed recently?

- Yes/ No

If "yes," after the change, did the child feel (Please circle one):

- Better/ Same/ Worse

Symptoms ("major"):

	☺	😐	☹
Decreased energy, fatigue	0	1 2	3 4
Weight gain or struggles	0	1 2	3 4
Feel "too hot"	0	1 2	3 4
Feel "too cold"	0	1 2	3 4

Symptoms ("minor")

Hair thinning or excessive loss	0	1 2	3 4
Headaches	0	1 2	3 4
"Brain fog"- trouble with learning, memory, making decisions	0	1 2	3 4
Depression	0	1 2	3 4
Irritability	0	1 2	3 4
Can't fall asleep	0	1 2	3 4
Can't stay asleep	0	1 2	3 4
Tired on waking	0	1 2	3 4
Snoring	0	1 2	3 4
Stop breathing while asleep	0	1 2	3 4

	☺	😐	☹
"Lump in throat" when swallow	0	1 2	3 4
Dislike tight collars	0	1 2	3 4
Sore or tender in lower neck	0	1 2	3 4
Chest tightness, sighing	0	1 2	3 4
Heart palpitations	0	1 2	3 4
Gastritis, use Tums, antacids, etc.	0	1 2	3 4
Abdominal gas and bloating	0	1 2	3 4
Constipation	0	1 2	3 4
Diarrhea/ colitis	0	1 2	3 4
Muscle aches, esp. low back	0	1 2	3 4
Stiff joints	0	1 2	3 4

Cold feet & hands 0 1 2 3 4
Dry skin 0 1 2 3 4
Brittle nails 0 1 2 3 4

Please remember there is no symptom that is unique to the thyroid. Every one of these symptoms could be caused by a number of different problems. The pattern gives us information.

Part V: Adrenal

History:

Has anyone in the family (blood relations) ever had adrenal problems? (circle):

- Yes/ No
If "yes," can you give details:

Has your child ever been diagnosed with adrenal gland trouble?

- Yes/ No
If "yes," what?:

History: (please circle)

Has child recently been treated with steroid drugs – pills or shot? (includes cortisone, Prednisone, Medrol, Celestone, Decadron and others)

- Yes/ No

Has child ever had a dramatic or bad reaction when using a steroid drug?

- Yes/ No

Symptoms:
Does child have problems with:

	☺	😐	☹
Low energy	0	1	2 3 4
Lack of endurance	0	1	2 3 4
Loss of strength	0	1	2 3 4
Crave salt	0	1	2 3 4
Low potassium	0	1	2 3 4
Lightheaded when get up quickly	0	1	2 3 4
Low blood pressure	0	1	2 3 4
Urinate at night	0	1	2 3 4
High blood sugar	0	1	2 3 4
Low blood sugar	0	1	2 3 4
Shallow sleep	0	1	2 3 4
Wake up tired	0	1	2 3 4
Can't remember dreams	0	1	2 3 4
Trouble handling stress	0	1	2 3 4
Easily upset or angered	0	1	2 3 4
Panic attacks	0	1	2 3 4
Hyperactivity	0	1	2 3 4
Inattention	0	1	2 3 4
Slow recovery from infections	0	1	2 3 4
Slow recovery from operations	0	1	2 3 4

Part VI: Stress

Prenatal:

How old was child's mother when child was born?
_____years old.

Among the children in the family, child is (circle one):

- Oldest
- Middle
- Youngest
- Only child

If child has siblings, how many?

Brothers:_____
Sisters: _____

What was the mother's state of mind during her pregnancy with child? (circle)

( ) Happy
( ) Unhappy, sad
( ) Angry
( ) Stressed
( ) Fearful
( ) Don't know

How was Mother's health when she was pregnant with child? (circle)

( ) Well
( ) ill, having problems with (Please circle any that apply):

- High blood pressure
- Diabetes
- Infection
- Accident or injury
- Operation
- Alcohol or drug use
- Bed-rest for premature labor
- Bleeding
-Other (please describe):

How was the mother's relationship with child's father during the child's pregnancy?

- Good
- Strained
- Bad
- None at all

Perinatal:

Were there any problems during the child's labor and delivery? (please circle):

- Premature rupture of membranes
- Premature labor
- Prolonged labor
- Emergency C-section
- Other (Please give any known details) :

History

Did your child have any problems during birth? (circle)

- Premature or late birth
- Fetal distress
- Cord around neck
- Blue baby
- Meconium aspiration
- Under-developed lungs
- Jaundice – longer in hospital
- Time in a neonatal isolette
- Other (please list if known):

What did child weigh at birth?
_____lbs.

Part VI: Stress *cont.*

First year of life:

As a newborn, child was:

( ) Breast-fed
( ) Bottle-fed

In the first year of life, did child have trouble with (please circle):

- Breast-feeding problems
- Formula intolerance, change
- Reflux and vomiting
- Colic and crying
- Sleeplessness for more than 6mos

- Eczema
- Bad diaper rashes

- Frequent ear infections
- Constantly running nose
- Chest infections, asthma
- Chronic diarrhea or constipation
- Operations
- Other (describe):

Were child's developmental milestones (talking, walking):
- Early
- Average – on time
- Late

Pre-school age:

During the pre-school years, how did child's parents relate to each other?

- Happy and peaceful
- Dealt well with differences
- "Strained"
- Fought in front of child
- Really badly !

When small, did child need medical treatment for:

- Ear infections
- Asthma
- Pneumonia
- Croup
- Tonsils/ Adenoids
- Other:

_____

Did child have any serious injuries or operations during the preschool years? (circle):

- No/ Yes
If "yes," please list:

_____

During the pre-school years, was child's mood most often:

- Happy
- Neutral
- Sad
- Angry
- Don't know

School age: Elementary
(Answer these depending on your child's age, of course)

When child started going to school, how did he/she like it?

- Loved it
- Liked it
- No bad feelings
- Hated it
- Don't know

What was the best thing about school?

_____

What was the worst thing about school?

_____

In elementary school, what was child's personality like?

- Outgoing
- Average
- Shy

Has child ever been:

- Teacher's Pet
- Class Clown
- Class Rebel
- Scapegoat
- Other:

What were your child's grades in Elementary school:

_____

Back then, child's height was (please circle):

- Tall
- Average
- Small

And child's build was:

- Thin
- Average
- Heavy-set

Did your child have any health problems requiring medical care at this age?

- No/ Yes
If so, please list:

_____

Did your child have any injuries or operations while in elementary school?

- No/ Yes
If so, please list:

_____

Has child been diagnosed "hyperactive" or given drugs for behavior when in school?

- No/ Yes
If drugs used, list which:

_____

Has your child had:

- Stuttering/ stammering
- Bedwetting

School Age: Jr. High

Has your child had a big problem with acne? (circle)
- No/ Yes
Has your child's body type changed significantly?

- No
- Yes, from thin to heavier
- Yes, from heavy to thinner

Did child's grades change in Middle or Jr. High school?

- No
- Yes, they got worse
- Yes, they got better
- Yes, they had ups & downs
If yes, why?

Did behavior or relations with teachers and friends suffer in Middle school?

- No
- Yes

High school age:

Did your child's grades change in High school?

- No
- Yes, they got worse
- Yes, they got better
- Yes, they had ups & downs

If yes, why?

While in High school, have there been problems with:

- Relations with classmates
- Run-ins with the Law
- Alcohol or drug use
- Health problems
- Operation or injury

Activity and exercise:
(check a box for your estimate)

During:	Elem.	Middle	High
None			
Occasional			
Frequent			
Constant			

During childhood and through High school, has your child been bereaved by the loss of a loved one?

- No
- Yes (Please explain, if you wish)

During any time in childhood or teen years, has your child suffered from physical or emotional abuse?

- No
- Yes

(You need not answer, as you prefer.)

Have you suffered other stressful events at any time in your life that have not been covered here? You may use this space to write. Go to the back side of this paper if you need to write more.

Thanks.

Part VI: GYN

Menarche
(as applicable):

How old was child when she had her first menstrual period?

Did child's figure "fill out" earlier than her friends' did?

- No
- Yes, at age____years.

Compared to friends, did your child start having periods:

- At a younger age
- At the same age
- At an older age
- Don't really know

Compared to the women in the family, did your child start having periods:

- At a younger age
- At the same age
- At an older age
- Do not know

Early menstrual history

During the first four years of having periods, how many days did the flow last?

_____days.

During these years, were the menstrual cycles (circle whatever applies):

- Regular, even and easy
- Irregular and unpredictable
- Painful, requiring pain pills (check): Over the counter / Prescription
- Accompanied by heavy flow
- Accompanied by clots for_____days.

Has your child had to miss school because of menstrual problems?

- No
- Occasionally
- Half of the time
- More than half the time
- Monthly

Did child ever need to take "the Pill" to control her menstrual problems?

- No
- Yes, at age: _____years

Reason:

Hormone contraception:

Has the child ever taken the birth control pill?

- No
- Yes, for _____months/yrs.

Has the child used any other hormone contraception (Depo-Provera, "the Patch")?

- No
- Yes

If "yes," which?

Has there ever been difficulty in tolerating hormone birth control?

- No/ Yes

Current menstrual history:

Has your child ever had problems with premenstrual syndrome (PMS)?

- No/ Yes

If "yes," which treatment has helped the most?

What symptoms has PMS given the child?

Mood swings:
Irritable/angry
Weepy/sad
Headaches
Fluid retention
Pain (please note where):

_____

Other:

_____

Part VI: GYN *cont.*

Please indicate the date (actual or approximate) on which the most recent menstrual period started:

_____

If PMS is a problem, how long does it cause symptoms?

- A day or two
- A week
- Two weeks
- Other:

_____

Are there any mid-cycle problems (usually thought due to ovulation)?

- No
- Yes

If "yes," please describe:

How many days does the menstrual flow last?

_____days

Do clots pass during flow?

- No
- Yes, little ones
- Yes, big ones

If "yes," for how long?

_____days

Is the menstrual flow painful?

- No
- Yes

If "yes," for how long?

_____days

From the start of menstrual flow to the first day the flow starts again, how long are her complete menstrual cycles (usually 28 days)?

_____days
(If irregular, please give a range)

Have menstrual cycles or the pattern of her menstrual flow changed recently?

- No
- Yes

If "yes," in what way?

_____

_____

Family GYN history:

If any "blood relations" has experienced these important GYN problems, please circle the condition and then indicate who had it – mother, sister, mother's family or father's family.

- Multiple cysts of ovaries

- Fibroid tumors of Uterus

- Fibrocystic breasts

- Endometriosis

- Cancer of cervix

- Cancer of uterus

- Cancer of ovary

- Cancer of breast

Is there any other important information about her GYN history that we need to know? If so, please make note here:

Part VII: Blood sugar and insulin resistance

Has your child ever been tested for hypoglycemia?

- No
- Yes

If "yes," what test was done?

_____

- what was found?

_____

Does child have diabetes mellitus?

- No
- Yes

If "yes," which type?
- Type I "juvenile"
- Type II "adult-onset"

Are you following any particular diet plan, such as Weight Watchers,' Atkins,' South Beach or ADA?

- No
- Yes

If "yes," which one?

_____

If your child is following a diet plan, could you do it better?

- No
- Yes – If so, how?

Is the child hungry on waking up in the morning?

- No/ Yes.

What is the first thing your child drinks after getting up in the morning?

_____

How long has child been awake when drinking this?

_____hours

When child gets up in the morning, what is the first thing he or she eats?

_____

How long has the child been awake when first eating?
_____hours

Does child eat a snack before lunch?

- No/ Yes

Is there a snack after lunch?

- No/ Yes

Does your child crave sugar?

- No/ Yes

Does child crave bread, cereal, chips or "starches?"

- No/ Yes

Have you found that eating sugar makes your child act or feel badly?

- No
- Yes

If "yes," what have you noticed happening?

_____

Does child use sweeteners?
(circle all that you use)

- Stevia ("natural" herb)
- Splenda (sucralose)
- Nutra-sweet (aspartame)
- Sweet&Low (saccharine)
- Fructose
- "Alcohol sugars"
- Other:

Does child drink soda pop?
(circle all that you use)

- Regular
- Diet
- Decaf or "Caffeine-free"
- No caffeine

How many cans or bottles of soda pop are used daily?
_____=_____oz.

Does your child regularly chew gum, use hard candy or breath mints?

- No
- Yes

If "yes," what is used?

_____

- and how much daily?
_____pieces/packs

Does your child eat desserts?

- Never
- Rarely
- Less than half the time
- More than half the time
- Every day

Does child eat snacks around bed-time?

- Never
- Rarely
- Less than half the time
- More than half the time
- Every day

Does your child wake up at night and need to snack or have a drink (besides water)?

- No
- Yes

If "yes," how often:

_____

- and on what snack?

_____

Summary of symptoms
(circle all that apply, by severity)

	☺	😐	☹
Craving sweets	0	1	2 3 4
Need snacks often	0	1	2 3 4
Feel great after eating sugar	0	1	2 3 4
Feel badly after eating sugar	0	1	2 3 4
Digestive disturbances	0	1	2 3 4
Drowsiness	0	1	2 3 4
Sighing and yawning	0	1	2 3 4
Exhaustion	0	1	2 3 4
Faintness	0	1	2 3 4
Hyperactive	0	1	2 3 4
Nervousness	0	1	2 3 4
Worrying, unprovoked anxiety	0	1	2 3 4
Act anti-social	0	1	2 3 4
Overly aggressive behavior	0	1	2 3 4
Crying spells	0	1	2 3 4
Insomnia	0	1	2 3 4
Depression	0	1	2 3 4
Forgetfulness	0	1	2 3 4
Poor concentration	0	1	2 3 4
Confusion	0	1	2 3 4
Indecisiveness	0	1	2 3 4
Headaches	0	1	2 3 4
Blurred vision	0	1	2 3 4
Dizziness	0	1	2 3 4
Poor coordination	0	1	2 3 4
Numbness	0	1	2 3 4
Sense of internal trembling	0	1	2 3 4
Itching, crawling skin sensations	0	1	2 3 4
Heart palpitations, rapid pulse	0	1	2 3 4
Tremors, shakes	0	1	2 3 4
Cold sweats	0	1	2 3 4
Unconsciousness	0	1	2 3 4
Muscle pains	0	1	2 3 4
Leg cramps	0	1	2 3 4
Muscle twitches, jerks	0	1	2 3 4

Please note that these symptoms are remarkably nonspecific! However, when a sufficient number are present and significantly severe, the possibility of glucose and insulin imbalance is raised.

Your top three health goals

Imagine you have rubbed a Magic Lamp and out popped a Genie in a white coat – he's a magic *doctor!*

He offers you the customary 3 wishes – but he only fixes health problems. So, now you get to choose: What are your child's three biggest problems to be wished away?

Genies can be tricky, so be clear in your wishes and specific about what you want. Please write your 3 wishes on this page.

One last question:

How many doctors have you seen about these problems?

_____.

This completes the packet of questions we hope to review at your first visit in the office.

Please use the remaining space to note questions and comments that you wish to discuss at your visit with me.

Thank you for your hard work and time spent completing these questionnaires.

Alan B. McDaniel, M.D.