It’s Alimentary Health History Addendum for YOUTH

Did your child have colic as an infant? ☐ Yes ☐ No

If yes, please explain symptoms.

How was your child fed as an infant? ☐ Breast ☐ Bottle

What brand/kind of formula?

At what age was the child weaned?

Has your child had ear infections? ☐ Yes ☐ No

If yes, how often?

Do they typically occur in the same ear?

If so, which ear?

What was the age of first occurrence?

Has your child had any respiratory infections? ☐ Yes ☐ No

If yes, how often and for how long?

Does your child complain of arm or leg pain? ☐ Yes ☐ No

If yes, please explain symptoms.

Does your child eve complain of headaches? ☐ Yes ☐ No

If yes, how often?

Please describe symptoms.

Has your child been vaccinated? ☐ Yes ☐ No

Recently? ☐ Yes

Did/does your child have any reactions to vaccinations? ☐ Yes

If so, please explain.

Does your child consume any of the following? (Please select one)

Soda	☐ none	☐ One per day	☐ 2 or more cans per day
Sweets	☐ none	☐ One per day	☐ 2 or more servings per da
Milk/Dairy	☐ none	☐ twice per day	☐ >twice per day
Juice	☐ none	☐ twice per day	☐ >twice per day

Do you suspect that your child may drink alcohol? ☐ Yes ☐ No

Do you suspect that your child may use cigarettes? ☐ Yes ☐ No

Do you suspect that your child may use street drugs? ☐ Yes ☐ No

Are there smokers in the house? ☐ Yes ☐ No

Does your child get regular physical activity? ☐ Yes ☐ No

Please explain, and list any regular exercise activity or sport that your child participates in.

Is your child schooled or homeschooled? ☐ Schooled ☐ Homeschooled

Sleep Habits

How well does your child sleep?
☐ Well ☐ trouble falling asleep ☐ trouble staying asleep ☐ insomnia

Does your child wake up tired? ☐ Yes ☐ No

How many hours does your child sleep usually?

Does your child have nightmares? ☐ No ☐ Sometimes ☐ Often