Pediatric Functional Health History

Child's Name:	Date of Birth:	Today's Date:

Your responses to the following questions will assist Dr. Knight in evaluating your child's overall health. It will help in determining the assessments and treatments that are most appropriate and guide you child's r path to optimal health. Please read each question carefully and answer (or have your child answer) to the best of your ability. The more honest you are in your answers, the more useful this tool will be.

What is the main reason for your child's appointment with Dr. Knight?

Are there other issues, topics, etc. that you would like to discuss with Dr. Knight? Please specify.

Child's Medical History (Please check any of the below conditions that your child currently has or has had):

❒Allergies/ Hay Fever
❒Asthma
❒Attention Deficit Disorder
❒Blood pressure issue
❒Celiac disease
❒Chronic bronchitis
❒Cancer
❒Constipation
❒Dental problems
❒Depression
❒Developmental Delays
❒Diabetes
❒Eating disorder
❒Epilepsy
❒Environmental sensitivities
❒Food intolerance
❒ Frequent ear infections
❒ Frequent sore throats
❒ Frequent urinary tract infections
❒Gastroesophogeal reflux
❒Genetic disorder
❒Hyperactivity
❒Infection, chronic
❒Inflammatory bowel disease
❒Irritable bowel disease
❒Kidney or bladder disease
❒Learning disabilities
❒Liver or gallbladder disease
❒Mental illness
❒Migraine headaches
❒Neurological condition
❒Sinus condition
❒Thyroid condition
❒Obesity
❒Pneumonia
❒Skin problems
❒Ulcers
❒_____
❒_____
❒_____

Please list treatments you are currently using for your child' health issues: (Supplements,prescription or over the counter drugs, diet, lifestyle) The more specific you can be the better.

Please list any treatments that you have tried using for your child's current issues that you have not felt to be effective:

<u>Family Health History -Parents, Grandparents and Siblings</u> (Please check all that apply):

❒Arthritis	❒Diabetes	❒Learning disabilities
❒Asthma	❒Drug addiction	❒Mental illness
❒Alcoholism	❒Eating disorder	❒Migraine headaches
❒Alzheimer's disease	❒Genetic disorder	❒Neurological disorders
❒Autoimmune disease	❒Glaucoma	❒Obesity
❒Cancer	❒Heart disease	❒Osteoporosis
❒Celiac /gluten intolerance	❒Infertility	❒Stroke
❒Depression	❒Inflammatory bowel disease	❒Suicide

Child's Prenatal and Birth History:

Place of Birth: _____ ❒ Planned Pregnancy ❒ Unplanned pregnancy

❒ Adopted

❒ Infertility problems If so, treatments to achieve pregnancy:_____

Problems during the pregnancy (describe)_____

Significant events or stressors during the pregnancy (describe)_____

_____

Prenatal exposures: (mother exposed to these during pregnancy)

❒Alcohol ❒Tobacco ❒ Substance use ❒ Seafood ingestion: how often/ type?_____
Environmental toxins such as pesticides, herbicides, toxic waste, or mercury? ❒ yes ❒ no

If yes, please specify:_____

Birth/labor:

❒ Vaginal birth ❒ Caesarean Section (reason) _____

❒ Premature birth (how early)_____❒ Over due (how long)_____

Medical interventions during labor/at birth:

❒ Induced ❒ Epidural ❒ Pain medications during labor ❒ Forceps ❒ Vacuum
❒Umbilical cord around neck ❒ Breech ❒General anesthesia at birth

Medical interventions after birth?

❒ Resuscitation ❒ IV's ❒ Lab testing

❒ Newborn Intensive Care Nursery? Why/How long?_____

_____

❒ Prolonged separation after birth for baby? Why/ How long?_____

_____

Other significant birth history:_____

Postpartum

❒ Post partum complications in mother (describe)_____

_____

❒ Post partum depression in mother (describe)_____

_____

Is your child up to date with their immunization schedule? ❒ Yes ❒ No

If no, please explain_____

Has your child ever had an adverse reaction to an immunization? ❒ Yes ❒ No

If yes, please explain_____

Child's Nutrition and Eating Patterns:

Was your child:

❒ breast fed Age weaned _____

❒ Bottle fed What formula? _____ Age off bottle _____

Were there any issues with breast or bottle feeding? ❒ yes ❒ no

If yes, please describe:_____

Age when solids started?_____

First food introduced?_____

Were there any issues or reactions to food introduction? ❒ yes ❒ no

If yes, please describe:_____

How is your child's appetite? ❒ Excellent ❒Good ❒ Poor ❒ Excessive

Is your child a picky eater? ❒ yes ❒ no

If yes, were either of his/her parents picky eaters? ❒ yes ❒ no

Does your child eat breakfast? ❒ yes ❒ no

Do you eat meals together as a family? ❒ Usually ❒ Seldom ❒ Never

Number of times a week:_____

Is your child on a special diet? ❒ yes ❒ no Explain:_____

Child's Nutrition and Eating Patterns (Continued):

On the average, how many servings per day does your child eat from the following food groups?

_____Fruits _____ Sweets

_____Vegetables _____Processed Foods

_____ Grains (bread, cereal, pasta, rice etc.) _____ Fast Foods

_____Proteins (meat, fish, eggs, nuts, nut butters, beans, lentils etc.)

_____ Dairy

Number of cups of milk per day (cups: 8 oz = 1 cup)_____

Type of milk (circle) Cow: whole, 2%, skim, Rice, Soy, Other:_____

Does your child regularly drink or eat products containing caffeine? (coffee, tea, colas, chocolate) ❒ yes ❒ no

How many 8 oz servings per day on average? _____

How many 8oz glasses of water does your child consume per day on average? _____

Any recent weight loss? ❒ yes ❒no _____ pounds.

Any recent weight gain? ❒ yes ❒no _____ pounds.

Is your child currently trying to lose weight? ❒ yes ❒no

Is your child currently trying to gain weight? ❒ yes ❒no

Does your child crave certain foods? ❒ yes ❒no If yes, what?_____

Does your child avoid certain foods? ❒ yes ❒no If yes, what?_____

Do you buy organic foods? ❒ yes ❒no What percentage of foods do you buy organic?_____

Does your child have any adverse food reactions? (Allergies, sensitivities, intolerances) ❒ yes ❒no

If yes, please describe:_____

_____

Child's Elimination Patterns (urination and bowel movements)

Frequency of urinating (average times per day)_____

Pain with urination ❒ yes ❒ no

Bedwetting? ❒ yes ❒ no Day time wetting? ❒ yes ❒ no

Frequency of bowel movements: number per day_____ number per week_____

Child's Elimination Patterns (Continued)

General consistency of bowel movements: ❒loose ❒ soft ❒firm ❒hard ❒ other:_____

General color of bowel movements:_____

Pain or straining with BM's: ❒ yes ❒no

Intestinal gas: ❒ rare ❒ excessive ❒foul smelling ❒with pain

Incontinence of bowel movements (accidents) ❒ yes ❒ no

Child's Sleep Patterns:

How long does your child generally take to fall asleep? ❒ < 30 minutes ❒ 30-60 minutes ❒1 hour

Does your child watch television in bed? ❒ yes ❒ no

Does your child read in bed? ❒ yes ❒ no

Does your child snore while sleeping? ❒ yes ❒ no

Does your child have pauses or stop breathing while sleeping? ❒ yes ❒ no

Does your child have a history of obstructive sleep apnea? ❒ yes ❒ no

What time does your child go to bed during the week? _____ Weekend?_____

What time does your child generally fall asleep at night?_____

What time does your child get up during the week? _____Weekend?_____

Does your child have difficulty waking up in the morning? ❒ yes ❒ no

Is your child sleepy during the day? ❒ yes ❒ no What time are they the sleepiest?_____

Does your child take naps during the day? ❒ yes ❒ no Time of nap_____How long_____

Does your child remember their dreams? ❒ yes ❒ no

Does your child ever have nightmares or night terrors? ❒ yes ❒ no

Does your child complain of sore neck muscles in the morning? ❒ yes ❒ no

Does you child have a history of sleep walking? ❒ yes ❒ no

Where does your child currently sleep at night?_____

Is your child a restless sleeper? ❒ yes ❒ no

Child's Behavior/Attention

	Never	Sometimes	Often	Almost Always
Is your child forgetful?				
Does your child have difficulty paying close attention to details or make careless mistakes?				
Is it difficult for your child to pay attention during tasks and activities?				
Does your child have trouble listening when spoken to directly?				
Is it difficult for your child to follow through on instructions at home or at school?				
Does your child have trouble organizing tasks or activities?				
Does your child dislike or is reluctant to engage in tasks that require sustained concentration or mental effort?				
Does your child often lose items necessary for tasks or activities?				
Is your child easily distracted by what's going on around him/her?				
Is your child often "on the go" or act as if driven by a motor?				
Does your child fidget with his/her hands or feet or squirm when seated?				
Does your child leave his/her seat in situations when remaining seated is expected?				
Does your child run about or climb excessively in situations in which it is inappropriate?				
Does your child have difficulty engaging in leisure activities quietly?				
Does your child talk excessively?				
Does your child blurt out answers before questions have been completed?				
Does your child have difficulty waiting his/her turn?				
Does your child interrupt or intrude on others? (Butts into conversations or games)				

For the following questions please be honest, check all that apply, and answer "in general" as they apply to your child. Some questions are repeated in multiple sections, but make sure you answer them even if you have already answered it elsewhere in order to optimize the usefulness of this form.

Section 1

	Yes
1. Are their nails soft, cracked, or brittle?	
2. Is their skin dry, itchy, or flaking?	
3. Is their ear wax hard or do they tend to have ear wax built up in ears?	
4. Do they have tiny bumps on the back of their arms?	
5. Do they have dandruff?	
6. Are their joints frequently stiff or achy?	
7. Are they thirsty most of the time?	
8. Do they have less than two bowel movements a day?	
9. Are their stools hard or light in color?	
10. Do they have depression, ADHD, or memory loss?	
11. Do they have eczema?	
12. Do they have cradle cap (seborrheic dermatitis)?	
13. Do they eat fish?	
14. Are they of North Atlantic genetic descent (*Irish, Scottish, Welsh, English, Scandinavian)?*	

Section 2

	Yes
1. Do they frequently feel down or depressed?	
2. Are they physically a low energy person?	
3. Are they mentally a low energy person?	
4. Do they frequently struggle to get motivated to exercise or accomplish tasks?	
5. Do they frequently have trouble concentrating or focusing on things?	
6. Do they often want to sleep a lot?	
7. Do they frequently have trouble waking up in the morning?	

Section 3

	Yes
1. Is it hard for them to relax?	
2. Are they easily stressed out or overwhelmed?	
3. Is it common for them to feel overworked?	
4. Is their body stiff or does it often feel tight?	
5. Do they have trouble settling down to go to sleep?	
6. Are they bothered by loud noises, lights, or too much activity?	

Section 4

	Yes
1. Do they frequently have trouble falling asleep?	
2. Do they wake in the middle of the night and have trouble getting back to sleep?	
3. Do you wake too early in the morning?	
4. Do they crave carbohydrates such as bread and pasta?	
5.Do they often have low self esteem?	
6. Do they often have low self confidence?	
7. Do they tend to have obsessive thoughts or behaviors?	
8. Do you get the "winter blues" or suffer from "seasonal affective disorder"?	
9. Do they tend to be irritable, easily angered, or impatient?	
10. Are they afraid of heights, crowds, or public speaking?	
11. Do they tend to feel anxious or have you had panic attacks?	

Section 5

	Yes
1. Is their sense of taste impaired?	
2. Is their sense of smell impaired?	
3. Are their nails thin, brittle, or peeling?	
4. Do they have white spots on your nails?	
5. Do they have frequent colds or respiratory infections?	
6. Do they have frequent diarrhea or loose stools?	
7. Do they have eczema or psoriasis?	
8. Do they have acne?	
9. Do their wounds take a long time to heal?	
10. Do they have environmental or seasonal allergies?	
11. Do they have a poor appetite?	

Section 6

	Yes
1. Do they tend to be depressed?	
2. Do they tend to be irritable?	
3. Do they have attention deficit disorder?	
4. Do they get anxious easily?	
5. Do they frequently have trouble falling asleep?	
6. Do they have muscle twitching?	
7. Do you frequently get leg or hand cramps?	
8. Do they get frequent headaches or migraines?	
9. Do they have trouble swallowing?	
10. Are they sensitive to loud noises?	
11. Do they frequently feel tired?	
12. Do they have asthma?	
13. Do they tend to be constipated? (Less than 2 bowel movements a day)	
14. Do they tend to feel stressed?	
15. Do they have generalized muscle tightness or pain?	

Section 7

	Yes
1. Do they crave sweets?	
2. Do they get a boost in energy after eating sweets followed by a crash in energy?	
3. Do you have a family history or diabetes or insulin resistance?	
4. Are they cranky, tired or irritable if they miss a meal?	
5. Do they have trouble stopping eating sweets or carbohydrates once they start eating them?	
6. Are they often moody, impatient, or anxious?	
7. Do they have difficulty with memory or concentration?	
8. Does eating make them calm?	
9. Are they tired most of the time?	
10. Do they eat mainly carbohydrates (cereal, toast, muffin, bagel) for breakfast?	
11. Do they frequently skip breakfast?	
12. Do they have frequent temper tantrums or meltdowns?	

Section 8

	Yes
1. Do they experience bloating after meals?	
2. Do they experience belching or heartburn after meals?	
3. Do they experience flatulence after meals?	
4. Do they have frequent stomach aches?	
5. Do you they appear fatigued or have trouble concentrating after eating?	
6. Do supplements or medications give them stomach aches?	
7. Do they frequently have diarrhea?	
8. Do they frequently have constipation (less than one bowel movement a day)?	
9. Do they have undigested food in their stool?	
10. Do they have foul smelling stools?	
11. Do they have known or suspected food allergies, food intolerances, or food sensitivities?	
12. Do carbohydrates or sugar cause them to have bloating?	
13. Do they get frequent canker sores?	
14. Have they used antibiotics more than twice in the last three years?	
15. Have they had a history or currently have frequent ear infections or sore throats?	
16. Do they have a difficult time passing stools?	

Section 9

	Yes
1. Are they frequently constipated or have hard to pass stools?	
2. Do they only urinate two to three times a day?	
3. Do they rarely break a sweat?	
4. Do they experience fatigue, muscle aches, headaches, concentration, or memory problems?	
5. Do they drink out of plastic bottles on a daily basis?	
6. Do they drink unfiltered water?	
7. Do they consume foods containing artificial colors and or sodium benzoate?	
8. Do they live in a house that has lead paint?	
9. Does your family live in an urban or industrial area?	
10. Does your family use lawn or garden chemicals or have you home treated for bugs by an exterminator?	
11. Does your famliy use non-stick cookware?	
12. Do they frequently play on playground or athletic field that has been treated with pesticides?	
13. Do they eat tuna, halibut, or swordfish more than once a week?	
14. Are they bothered by any of the following odors (gasoline, perfume, new cars, fabric stores, dry cleaning, hair spray, cleaning products, fabric softeners, soaps, detergents, tobacco, or chlorinated water)?	
15. Do they have a negative reaction when they consume foods containing garlic, onions, MSG, sulfites, sodium benzoate, aged cheese, bananas, or chocolate?	
16. Do they frequently consume foods containing high fructose corn sugar?	
17. Do they frequently consume non organic apples, celery, strawberries, peaches, spinach, nectarines, grapes, peppers, potatoes, blueberries, lettuce, kale, meat, butter, other dairy products?	
18. Have they had jaundice (turned yellow) or have you been told they have Gilbert's syndrome?	
19. Do you have or have a family history of cancer?	
20. Do you have or have a family history of neurological conditions such as Parkinson's, Alzheimer's, multiple sclerosis, or ALS?	

Thank you for taking the time to complete this form. The answers will help assist Dr. Knight in determining the next steps helping you to achieve more optimal health. Please make sure that you return the completed form to Dr. Knight before the day of your visit so that he has ample time to review it. If you have any questions please call (207) 805-1129