Functional Health Institute

YOUTH HEALTH HISTORY

Patient Name: _____

Please take your time in filling out these forms
as honestly and accurately as possible.

HISTORY:

Did your child have colic as a baby? ○ Yes ○ No

Please indicate how your child was fed as a baby:

Breast – how long? _____

Formula – how long? _____ Kind of formula: _____

Does your child have a history of ear infections? ○ Yes ○ No

If "yes," at what age did first earache occur? _____

How frequently did/does your child experience earaches? _____

In which ear does earache/infection usually occur: ○ Right ○ Left ○ Both

Were earaches/infections generally treated with antibiotics? ○ Yes ○ No

Does your child have asthma? ○ Yes ○ No

Does your child have history of anemia? ○ Yes ○ No

Has your child been vaccinated? ○ Yes ○ No

Has your child been vaccinated recently? ○ Yes ○ No When last vaccinated: _____

Please list any known reactions to any vaccinations:

_____

Please list health conditions your child has been diagnosed with:

_____

List any drugs that your child is allergic to:

_____

PLEASE SELECT THE FREQUENCY OF CONSUMPTION OF THE FOLLOWING:

White flour products:	○ Daily	○ Few /Week	○ Few /Month	○ Never
Meat/fish:	○ Daily	○ Few /Week	○ Few /Month	○ Never
Fast foods:	○ Daily	○ Few /Week	○ Few /Month	○ Never
Refined carbohydrates:	○ Daily	○ Few /Week	○ Few /Month	○ Never
Juice:	○ Daily	○ Few /Week	○ Few /Month	○ Never

Is your child a vegetarian: ○ Yes ○ No

Please list physical activities or sports your child participates in:

_____
_____

How much water does your child drink daily? _____

Are there smokers in your child's home? ○ Yes ○ No

SURGERIES, ACCIDENTS, TRAUMAS: Please list any your child has had and include dates.

_____
_____
_____
_____
_____

SLEEP: Please check those which apply:

○ Sleeps well ○ Trouble falling asleep ○ Trouble staying asleep ○ Insomnia

Number of hours child typically sleeps each night: _____ Does child nap? ○ Yes ○ No

Do you keep child's room completely dark at night? ○ Yes ○ No

How often does your child have nightmares, if at all? ○ Never ○ Sometimes ○ Often

Form completed by: _____

Your relationship to the child: _____