

HEALTH QUESTIONNAIRE

PERSONAL HISTORY

1. Nap time: _____ Length _____ Nap Toy: _____

2. Eating Habits:

a. Meal time _____ snack: yes _____ no _____

b. Food likes: _____

c. Dislikes: _____

If your child cannot eat some food, which is on our menu, we ask that you please send a lunch on that particular day.

3. Bowel Habits:

Frequency of BM _____ usual time _____

Constipation &/or diarrhea: _____

Partially trained _____ completely trained _____

4. Behavior:

Temper tantrums: _____ biting _____ scratching _____

Pulling hair: _____ other _____

5. Socializing:

a. Plays with others _____ b. prefers to play alone: _____

SPECIAL NEEDS

1. Vision (glasses) _____

2. Hearing _____

3. Speech _____

4. Activity Restrictions _____

5 Allergies: Food _____ Pollens _____ Medication _____

MEDICAL HISTORY

1. Illness: Measles _____ Mumps _____ Chicken pox _____
Diabetes _____ Whooping cough _____ Other _____

2. Frequent colds or sore throat? _____

3. Ear Infections? _____

4. Respiratory conditions?

Bronchitis? _____ Pneumonia: _____ Asthma _____

5. Seizure Disorder? _____

6. Hospitalizations? _____

Surgery? (Explain) _____

7. Is there anything special we should know about your child's medical past? _____

Emotional Development? _____

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