1. Your child's overall health:
   - Very Healthy
   - Healthy
   - Somewhat Sick
   - Unhealthy
   - Not sure

2. Your child’s activity level:

3. Does your child take formula?
   - Yes  Brand: ___________________
   - No

4. Your child’s appetite:
   - Huge
   - Good
   - Fair
   - Small

5. Your child’s food choices:
   - Eats anything
   - Eats a wide variety of foods but rejects some
   - Eats a very limited number of foods

6. Does your child take vitamins?
   - Yes
   - No

7. Does your family used iodized table salt?
   - Yes
   - No
   - Not sure

8. Does your family use fluoridated water?
   - Yes
   - No
   - Not sure

9. Does your child have digestive problems?
   - Yes – Spitting up
   - Yes – Vomiting
   - Yes – Pain after eating
   - No

10. What do you think is the cause of the digestive problem?

11. How many bowel movements does your child have per day? ________

12. Bowel movement consistency:
   - Like water
   - Like peanut butter
   - Like clay
   - Not sure

13. Does the child have any streaks of blood or mucous in the stool?
   - Yes
   - No
   - Not sure

14. Has anyone in the family, other than your child, developed gastrointestinal symptoms recently?
   - Yes
   - No

15. Does your child have any scars?
   - Yes
   - No

16. Does your child have any areas of hair loss on the scalp?
   - Yes
   - No

17. Does your child have any type of rash?
   - Yes – Individual bumps
   - Yes – Generalized redness
   - Yes – Itchiness
   - No (please skip to question #20)
18. If yes, What is the cause of rash?
   - Allergy
   - Infection
   - Insect bite
   - Not sure

19. If yes, How long has the rash been present?
   - Since union
   - Weeks
   - Days

20. Does your child have nasal discharge?
   - Yes – Acute
   - Yes – Chronic
   - No

21. Does your child have any birthmarks?
   - Yes
   - No
   - Not sure

22. Does your child have a cough?
   - Yes – Acute
   - Yes – Chronic
   - No (please skip to question 24)

23. If yes, What type of cough?
   - Dry
   - Mucous
   - Wheezy
   - Combination of above
   - Not sure

24. Has your child had a fever within the last 2 weeks?
   - Yes
   - No

25. Does your child appear to have ear complaints?
   - Yes – Pulling ears
   - Yes – Cries and holds ears
   - Yes – Ear drainage
   - No

26. How well does your child hear?
   - Startles with loud noises
   - Looks for the source of a quiet sound occurring behind him/her
   - Hears very quiet sounds originating from another room
   - Not sure

27. Does your child have a lazy eye?
   - Yes
   - No
   - Not sure

28. How well does your child see?
   - Very well
   - Well
   - Not sure
   - Worried

29. Is your child in pain?
   - Yes
   - No
   - Not sure

30. Your child’s muscle strength:
   - Very strong
   - Average strength
   - Weak
   - Not sure

31. Your child’s muscle coordination:
   - Very coordinated
   - Average coordination
   - A little clumsy
   - Very uncoordinated
   - Not sure

32. Is your child:
   - Right hand dominated
   - Left hand dominated
   - Ambidextrous (uses both hands equally)

33. Comments:
   ___________________________________
   ___________________________________
   ___________________________________
   ___________________________________