Pediatric Comprehensive Health Questionnaire

Demographic Information

☐Mr. ☐Ms. ☐Miss ☐Mrs. ☐Dr.

First Name: _____ Middle Initial: ____ Last Name:_____

Age: _____ Date of Birth: _____ Height: _____ Weight: _____

Ethnicity: ☐Native American/Alaska Native ☐Asian ☐African American ☐Hispanic/Latino ☐Native Hawaiian/Pacific Islander ☐White ☐Other. ☐Decline to Answer

Responsible Party/Legal Guardian (if different than patient): _____

Relationship: _____

Contact Information

Address: _____

City: _____State/Prov: _____ Zip/PC: _____

Email: _____ Home/Cell: _____

Employer: _____ Work Phone: _____

Provider Information Referral Source: _____

Dental Provider Office: _____ Last Visit: _____

Dentist Name: _____ Office Phone: _____

City: _____State/Prov: _____ Zip/PC: _____

Primary Care Physician Office: _____ Last Visit: _____

Doctor Name: _____ Office Phone: _____

City: _____State/Prov: _____ Zip/PC: _____

Additional Provider Office: _____ Last Visit: _____

Doctor Name: _____ Office Phone: _____

City: _____State/Prov: _____ Zip/PC: _____

Patient/Parent Signature: _____ Date: _____

What is your chief concern and reason for this visit:

_____

Does your child currently experience any of the following symptoms?

Indicate all that apply and number your top chief complaints 1-4

Sleep Conditions

Regular bedtime	☐ Yes ☐ No	Resist going to bed	☐ Yes ☐ No
Difficulty falling asleep	☐ Yes ☐ No	Awakenings from sleep	☐ Yes ☐ No
Difficulty awakening in AM	☐ Yes ☐ No	Poor sleeper	☐ Yes ☐ No
Snoring	☐ Yes ☐ No	Mouth breathing	☐ Yes ☐ No
Restless sleep	☐ Yes ☐ No	Sweating when sleeping	☐ Yes ☐ No
Daytime sleepiness	☐ Yes ☐ No	Poor appetite	☐ Yes ☐ No
Nightmares	☐ Yes ☐ No	Sleepwalking	☐ Yes ☐ No
Sleep talking	☐ Yes ☐ No	Sleep terrors	☐ Yes ☐ No
Leg kicking	☐ Yes ☐ No	Getting out of bed	☐ Yes ☐ No
Teeth grinding	☐ Yes ☐ No	Growing pains	☐ Yes ☐ No
Bed wetting	☐ Yes ☐ No	Daytime sleepiness	☐ Yes ☐ No
Naps after school	☐ Yes ☐ No	Falls asleep at school	☐ Yes ☐ No

Other _____ _____ _

Pain Conditions

Headaches	☐ Yes ☐ No	Jaw pain	☐ Yes ☐ No
Neck pain	☐ Yes ☐ No	Back pain	☐ Yes ☐ No
Noises in jaw joints	☐ Yes ☐ No	Difficulty opening mouth	☐ Yes ☐ No
Growing pains	☐ Yes ☐ No		

Other _____ _____

Other Conditions

Nasal congestion	☐ Yes ☐ No	Difficulty breathing through nose	☐ Yes ☐ No
Bronchitis	☐ Yes ☐ No	Asthma	☐ Yes ☐ No
Allergies	☐ Yes ☐ No	Frequent colds or flu	☐ Yes ☐ No
Ear infections	☐ Yes ☐ No	Throat infections	☐ Yes ☐ No
Tonsillitis	☐ Yes ☐ No	Acid reflux (GERD)	☐ Yes ☐ No
Delayed growth	☐ Yes ☐ No	Fussy eater	☐ Yes ☐ No
Excessive weight	☐ Yes ☐ No	Tubes in ears	☐ Yes ☐ No
Hearing disorders	☐ Yes ☐ No	Speech problems	☐ Yes ☐ No
Vision problems	☐ Yes ☐ No	Seizures/epilepsy	☐ Yes ☐ No
Chromosomal disorders	☐ Yes ☐ No	Eczema	☐ Yes ☐ No
Tooth crowding	☐ Yes ☐ No	Delayed tooth eruption	☐ Yes ☐ No
Tongue-tie	☐ Yes ☐ No	Drooling while eating	☐ Yes ☐ No
Autism	☐ Yes ☐ No	Developmental delay	☐ Yes ☐ No
Hyperactivity ADHD	☐ Yes ☐ No	Anxiety/Panic Attacks	☐ Yes ☐ No
Obsessive Compulsive Disorder	☐ Yes ☐ No	Depression	☐ Yes ☐ No
Learning disability	☐ Yes ☐ No	Drug abuse	☐ Yes ☐ No
Behavioral disorder	☐ Yes ☐ No	Psychiatric care	☐ Yes ☐ No

Other _____

Surgical History

Tonsils removed	☐ Yes ☐ No	Adenoids removed	☐ Yes ☐ No
Tubes in ears	☐ Yes ☐ No	Tongue-tie release	☐ Yes ☐ No
Tooth extractions	☐ Yes ☐ No		

Other _____

What are the results you are seeking from treatment:

_____

Allergic Reactions

Patient/Parent Signature: _____ Date: _____

Please check any and all medications or substance that have caused an allergic reaction

☐ Anesthetics ☐ Antibiotics ☐ Aspirin
☐ Barbiturates ☐ Codeine ☐ Iodine
☐ Latex ☐ Metals ☐ Plastics
☐ Penicillin ☐ Sedatives ☐ Sulfa
☐ Food Allergies/Sensitivities
Other:

Current Medications

Please list all medications and supplements (over-the-counter and prescription) you are taking and the reason you take them.

Medication	Dosage	Reason for Taking

☐ See attached list

Previous Treatment, Medications and Other Therapies Attempted For The Condition We Are Evaluating

Treatment/Med/Therapy	Doctor/Provider	Approx. Date of Tx	Helpful (y/n)

☐ See attached list

History of Symptoms

On what date, or approximate date, did the condition you are seeking treatment for occur?
Are any of the conditions listed or was your chief complaint caused by a motor vehicle accident? ☐Yes ☐No
If yes, what conditions: _ Date of accident: _
Does any family member have a sleep breathing disorder? ☐Yes ☐No If yes, explain:

Has your child had any of the following:

Orthodontic Treatment? ☐Yes ☐No
Stopped breathing during sleep? ☐Yes ☐No
Sleep Study? ☐Yes ☐No
☐ HST (Home Sleep Test) ☐PSG (Polysomnogram in Sleep Lab) Date: Result: _____
Positive Airway Pressure Devices Used? ☐CPAP ☐BiPAP ☐ASV ☐APAP
Orthodontic Appliance? ☐Yes ☐No Type: _____
Myofunctional Therapy? ☐Yes ☐No Type: _____
Other Therapy? ☐Yes ☐No Type: _____
Breastfed ☐Yes ☐No Until what age? _____
Bottle fed ☐Yes ☐No Until what age? _____
Pacifier ☐Yes ☐No Until what age? _____
Thumb or Finger Habit ☐Yes ☐No Until what age? _____
Other: _____

Patient/Parent Signature: _____ Date: _____

Medical History – Patient and Family

Do you have or have experienced any of the following

☐ **I HAVE NO FAMILY HX**

	PATIENT HX	FAMILY HX
AIDS/HIV	☐ Yes ☐No	
Anemia	☐ Yes ☐No	☐Fam Hx
Anxiety	☐ Yes ☐No	☐Fam Hx
Asthma	☐ Yes ☐No	☐Fam Hx
Awakenings from Sleep ___ x	☐ Yes ☐No	☐Fam Hx
Bleeding Easily	☐ Yes ☐No	☐Fam Hx
Birth Defects	☐ Yes ☐No	☐Fam Hx
Bruising Easily	☐ Yes ☐No	☐Fam Hx
Cancer of _____	☐ Yes ☐No	☐Fam Hx
Chemo	☐ Yes ☐No	☐Fam Hx
Chronic Fatigue	☐ Yes ☐No	☐Fam Hx
Cold Hands and Feet	☐ Yes ☐No	☐Fam Hx
COPD	**☐ Yes**	**☐No ☐Fam Hx**
Depression	**☐ Yes**	**☐No ☐Fam Hx**
Diabetes	**☐ Yes**	**☐No ☐Fam Hx**
Difficulty Concentrating	☐ Yes ☐No	☐Fam Hx
Difficulty Breathing at Night	☐ Yes ☐No	☐Fam Hx
Dizziness	☐ Yes ☐No	☐Fam Hx
Eating Disorder	☐ Yes ☐No	☐Fam Hx
(EDS) Ehlers-Danlos Syndrome	☐ Yes ☐No	☐Fam Hx
Emphysema	☐ Yes ☐No	☐Fam Hx
Epilepsy	☐ Yes ☐No	☐Fam Hx
Excessive Thirst	☐ Yes ☐No	☐Fam Hx
Fainting	☐ Yes ☐No	☐Fam Hx
Fibromyalgia	☐ Yes ☐No	☐Fam Hx
Fluid Retention	☐ Yes ☐No	☐Fam Hx
Frequent Colds/Flu	☐ Yes ☐No	☐Fam Hx
Frequent Cough	☐ Yes ☐No	☐Fam Hx
Frequent Ear Infections	☐ Yes ☐No	☐Fam Hx
Frequent Sore Throat	☐ Yes ☐No	☐Fam Hx
Gastroesophogeal Reflux	☐ Yes ☐No	☐Fam Hx
Glaucoma	☐ Yes ☐No	☐Fam Hx
Hay Fever	☐ Yes ☐No	☐Fam Hx
Hearing Impairment	☐ Yes ☐No	☐Fam Hx
Heart Attack	☐ Yes ☐No	☐Fam Hx
Heart Disease	**☐ Yes**	**☐No ☐Fam Hx**
Heart Murmur	☐ Yes ☐No	☐Fam Hx
Heart Pacemaker	☐ Yes ☐No	☐Fam Hx
Heart Palpitations	☐ Yes ☐No	☐Fam Hx
Heart Valve Replacement	☐ Yes ☐No	☐Fam Hx
Hemophilia	☐ Yes ☐No	☐Fam Hx
Hepatitis	☐ Yes ☐No	☐Fam Hx
High Blood Pressure	**☐ Yes**	**☐No ☐Fam Hx**
History of Substance Abuse	☐ Yes ☐No	☐Fam Hx
Huntington's Disease	☐ Yes ☐No	☐Fam Hx
Hypoglycemia	☐ Yes ☐No	☐Fam Hx
Insomnia	**☐ Yes**	**☐No ☐Fam Hx**
Intestinal Disorder	☐ Yes ☐No	☐Fam Hx
Irregular Heartbeat	☐ Yes ☐No	☐Fam Hx
Kidney Disease	☐ Yes ☐No	☐Fam Hx
Leukemia	☐ Yes ☐No	☐Fam Hx
Liver Disease	☐ Yes ☐No	☐Fam Hx
Low Blood Pressure	☐ Yes ☐No	☐Fam Hx
Meniere's Disease	☐ Yes ☐No	☐Fam Hx
Memory Loss	☐ Yes ☐No	☐Fam Hx
Migraines	☐ Yes ☐No	☐Fam Hx
Mitral Valve Prolapse	☐ Yes ☐No	☐Fam Hx
Multiple Sclerosis	☐ Yes ☐No	☐Fam Hx
Muscle Aches	☐ Yes ☐No	☐Fam Hx
Muscle Fatigue	☐ Yes ☐No	☐Fam Hx
Muscle Spasms	☐ Yes ☐No	☐Fam Hx
Muscular Dystrophy	☐ Yes ☐No	☐Fam Hx
Neuralgia	☐ Yes ☐No	☐Fam Hx
Nervous system Disorder	☐ Yes ☐No	☐Fam Hx
Osteoarthritis	☐ Yes ☐No	☐Fam Hx
Osteoporosis	☐ Yes ☐No	☐Fam Hx
Ovarian Cyst	☐ Yes ☐No	☐Fam Hx
Parkinson's Disease	☐ Yes ☐No	☐Fam Hx
Poor Circulation	☐ Yes ☐No	☐Fam Hx
(POTS) Postural Orthostatic Tachycardia Syndrome	☐ Yes ☐No	☐Fam Hx
Psychiatric Care	☐ Yes ☐No	☐Fam Hx
Radiation	☐ Yes ☐No	☐Fam Hx
Recent Weight Gain	☐ Yes ☐No	☐Fam Hx
Recent Weight Loss	☐ Yes ☐No	☐Fam Hx
Rheumatic Fever	☐ Yes ☐No	☐Fam Hx
Rheumatoid Arthritis	☐ Yes ☐No	☐Fam Hx
Scarlet Fever	☐ Yes ☐No	☐Fam Hx
Shortness of Breath	☐ Yes ☐No	☐Fam Hx
Skin Disorder	☐ Yes ☐No	☐Fam Hx
Sinus Problems	☐ Yes ☐No	☐Fam Hx
Slow Healing Sores	☐ Yes ☐No	☐Fam Hx
Speech Difficulties	☐ Yes ☐No	☐Fam Hx
Stroke	**☐ Yes**	**☐No ☐Fam Hx**
Swollen or Painful Joints	☐ Yes ☐No	☐Fam Hx
Thyroid Disease	**☐ Yes**	**☐No ☐Fam Hx**
Tired Muscles	☐ Yes ☐No	☐Fam Hx
Tuberculosis	☐ Yes ☐No	☐Fam Hx
Urinary Tract Disorder	☐ Yes ☐No	☐Fam Hx

OTHER _____

_____

Patient/Parent Signature: _____ Date: _____

BEARS SLEEP SCREENING

The "BEARS" instrument is divided into five major sleep domains, providing a comprehensive screen for the major sleep disorders affecting children in the 2- to 18-year old range. Each sleep domain has a set of age-appropriate "trigger questions" for use in the clinical interview.

B = bedtime problems
E = excessive daytime sleepiness
A = awakenings during the night
R = regularity and duration of sleep
S = snoring

A parent answers questions in **black**, the subject child answers questions written in **blue**:

Symptom	Age Toddler/Preschool (2-5 years)	Age School Age (6-12 years)	Age Adolescent (13-18 years)
1. Bedtime Problems	Does your child have any problems going to bed? Y N	Does your child have any problems at bedtime? (P) Y N Do you have any problems going to bed? (C)	Do you have any problems falling asleep at bedtime? (C) Y N
2. Excessive Daytime Sleepiness	Does your child seem overtired or sleepy a lot during the day? Y N	Does your child have difficulty waking in the morning, seem sleepy during the day or take naps? (P) Y N Do you feel tired a lot? (C) Y N	Do you feel sleepy a lot during the day? Y N In School? Y N While Driving? (C) Y N
3. Awakenings during the night	Does your child wake up a lot at night? (P) Y N	Does your child seem to wake up a lot at night? Y N Any sleepwalking or nightmares? (P) Y N Do you wake up a lot at night? Y N Have trouble getting back to sleep? (C) Y N	Do you wake up a lot at night? Y N Have trouble getting back to sleep? (C) Y N
4. Regularity and duration of sleep	Does your child have a regular bedtime and wake time? Y N What are they?	What time does your child go to bed and get up on school days? ——— Weekends? Do you think he/she is getting enough sleep? (P) Y N	What time do you usually go to bed on school nights? _ Weekends? How much sleep do you usually get? (C) _
5. Snoring	Does your child snore a lot or have difficult breathing at night? Y N	Does your child have loud or nightly snoring or any breathing difficulties at night? (P) Y N	Does your teenager snore loudly or nightly? (P) Y N

(P) Parent-directed question
(C) Child-directed question

Source: "A Clinical Guide to Pediatric Sleep: Diagnosis and Management of Sleep Problems" by Jodi A. Mindell and Judith A. Owens; Lippincott Williams & Wilkins

Patient/Parent Signature: _____ Date: _____

PEDIATRIC SLEEP QUESTIONNAIRE (PSQ)

1. While sleeping does your child….

Snore more than half the time?	☐ Yes	☐ No
Always snore?	☐ Yes	☐ No
Snore loudly?	☐ Yes	☐ No
Have "heavy" or loud breathing	☐ Yes	☐ No
Have trouble breathing or struggle to breathe	☐ Yes	☐ No
Have you ever seen your child stop breathing during the night?	☐ Yes	☐No

2. Does your child…..

Tend to breathe through the mouth during the day?	☐ Yes	☐ No
Have a dry mouth on waking up in the morning?	☐ Yes	☐ No
Occasionally wet the bed?	☐ Yes	☐ No
Wake up feeling unrefreshed in the morning?	☐ Yes	☐ No
Have a problem with sleepiness during the day?	☐ Yes	☐ No
Have a teacher or other supervisor comment that your child appears sleepy during the day?	☐ Yes	☐ No
Find it hard to wake your child up in the morning?	☐ Yes	☐ No

3. Did your child stop growing at a normal rate at any time since birth?

☐ Yes ☐ No

4. Is your child overweight? ☐ Yes ☐ No

5. This child often…..

Does not seem to listen when spoken to directly.	☐ Yes	☐ No
Has difficulty organizing tasks and activities.	☐ Yes	☐ No
Is easily distracted by extraneous stimuli.	☐ Yes	☐ No
Fidgets with hands or feet or squirms in seat.	☐ Yes	☐ No
Is "on the go" or often acts as if "driven by a motor".	☐ Yes	☐ No
Interrupts or intrudes on others (butts into conversations or games)	☐ Yes	☐ No

Patient/Parent Signature: _____ Date: _____

Severity Measure for Depression—Child Age 11–17*

*PHQ-9 modified for Adolescents (PHQ-A)—Adapted

Instructions: How often have you been bothered by each of the following symptoms during the past **7 days**? For each symptom put an "**X**" in the box that best describes how you have been feeling.

	Not at all (0)	**Several days (1)**	**More than Half the days (2)**	**Nearly every day (3)**
Little interest or pleasure in doing things?	☐	☐	☐	☐
Feeling down, depressed, irritable, or hopeless?	☐	☐	☐	☐
Trouble falling/staying asleep, sleeping too much?	☐	☐	☐	☐
Feeling tired or having little energy?	☐	☐	☐	☐
Poor appetite, weight loss or overeating?	☐	☐	☐	☐
Feeling bad about yourself or that you are a failure or have let yourself or your family down?	☐	☐	☐	☐
Trouble concentrating on things, such as Schoolwork, reading or watching TV?	☐	☐	☐	☐
Moving or speaking so slowly that other people could have noticed. Or the opposite, being so fidgety or restless that you have been moving around a lot more than usual?	☐	☐	☐	☐
Thoughts that you would be better off dead Or of hurting yourself in some way?	☐	☐	☐	☐

Column Totals _____ + _____ + _____ + _____

Total /Partial Raw Score _____

Prorated Total Raw Score (if 1-2 items left unanswered) _____

Patient/Parent Signature: _____ Date: _____

Generalized Anxiety Disorder (GAD-7) Questionnaire

Over the last two weeks, how often have you been bothered by the following problems?

	Not at all (0)	**Several days (1)**	**More than Half the days (2)**	**Nearly every day (3)**
Feeling nervous, anxious, or on edge	☐	☐	☐	☐
Not being able to stop or control worrying	☐	☐	☐	☐
Worrying too much about different things	☐	☐	☐	☐
Trouble relaxing	☐	☐	☐	☐
Being so restless that it is hard to sit still	☐	☐	☐	☐
Becoming easily annoyed or irritable	☐	☐	☐	☐
Feeling afraid, as if something awful might happen	☐	☐	☐	☐

Totals: _____ + _____ + _____ + _____

Total: _____

If you checked off any problem on the questionnaire so far, how difficult have they made it for you to do your work, take care of things at home, or get along with other people?

☐ **not difficult at all** ☐ **somewhat difficult** ☐ **very difficult** ☐ **extremely difficult**

I authorize the release of all examination findings and diagnosis, report and treatment plans, etc., to any referring or treating health care provider. I additionally authorize the release of any medical information to insurance companies, third party billing companies, or for legal documentation to process claims. I understand that I am responsible for all charges incurred for my treatment regardless of insurance coverage.

Patient/Parent Signature: _____ Date: _____