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HEALTH QUESTIONNAIRE-CHILD

This questionnaire is designed to help you examine some of the many factors affecting your child's health. It is long and detailed, but the time spent in answering all the questions is well worthwhile. Your child's family history of disease, past illnesses, health habits, your home and school or day care environment all have a direct bearing on health. **PLEASE FILL OUT THIS QUESTIONNAIRE AS CAREFULLY AS YOU CAN.** Many details that seem insignificant to you may have an important bearing on your child's diagnosis and treatment. Please add any further information that might be of help, either in the margins or on a separate piece of paper. The questionnaire will be kept confidential and is looked at only by the doctor.

The following information would also be very helpful:

· **A short written description of your child's main medical problems, and what help you would like from Dr. Coombs.**

· **A list of treatments that you child has undertaken in the past, both conventional and alternative, and their effect on his/her condition.**

· **A complete list of your child's medications, both past and present, both drugs and nutritional supplements. Include both the name and dose of each medication.**

· **Copies of previous medical reports and laboratory tests, especially if your child has been under the care of a specialist.** [If these are not easily obtained by you beforehand, a request can be sent from this office at the time of your first visit.]

• PLEASE REMEMBER TO BRING THE COMPLETED QUESTIONNAIRE WITH YOU TO THE APPOINTMENT! DO NOT TRY TO SEND IT HERE IN ADVANCE. It is not worth the risk of having it delayed in the mail.

• Your first appointment has been booked for 50 minutes. THIS TIME IS SET ASIDE SPECIFICALLY FOR YOUR CHILD. Since there are others who are waiting for appointments, PLEASE GIVE THIS OFFICE AS MUCH NOTICE AS POSSIBLE IF YOU ARE UNABLE TO ATTEND. Patients who fail to show for an initial appointment will not be given any further appointments with Dr. Coombs.

• PLEASE CALL TO CONFIRM YOUR APPOINTMENT A FEW DAYS (MORE THAN ONE BUSINESS DAY) BEFOREHAND.

• MANY OF OUR PATIENTS ARE VERY SENSITIVE TO PERFUME AND SCENTED PRODUCTS. PLEASE DO NOT WEAR THESE TO YOUR APPOINTMENT.

• DIRECTIONS TO OUR OFFICE IN PERTH ARE POSTED IN THE 'DIRECTIONS' SECTION OF THE WEBSITE.

NAME_____ **DATE OF BIRTH** yy / mm / dd **1**
ADDRESS _____ **PHONE #: HOME** (____)_____-_____
_____**POSTAL CODE**_____ **WORK**(____)_____-_____
OHIP:_____ **VERSION CODE:**_____ **Date Questionnaire Completed :** yy / mm / dd

PAST MEDICAL HISTORY:

Have you ever had:			**Year**
Measles	yes	no	
Mumps	yes	no	
Whooping cough	yes	no	
Polio	yes	no	
Scarlet fever	yes	no	
Diphtheria	yes	no	
Meningitis	yes	no	
Infectious mono	yes	no	
Eczema	yes	no	
Tuberculosis	yes	no	
Exposure to TB	yes	no	
Malaria	yes	no	
Hives	yes	no	
Cancer	yes	no	
Venereal disease	yes	no	
Arthritis	yes	no	
Back trouble	yes	no	
Bronchitis	yes	no	
Pneumonia	yes	no	
Pleurisy	yes	no	
Asthma	yes	no	
Emphysema	yes	no	
Rheumatic fever	yes	no	
High blood pressure	yes	no	
Heart disease	yes	no	
Anaemia	yes	no	
Bleeding tendency	yes	no	
Blood transfusion	yes	no	
Hepatitis (yellow jaundice)	yes	no	
Ulcer	yes	no	
Haemorrhoids	yes	no	
Bladder infections	yes	no	
Kidney disease	yes	no	
Hay fever / sinusitis	yes	no	
Glaucoma	yes	no	
Nose bleeds	yes	no	
Bowel disease	yes	no	
Emotional illness	yes	no	
Other (describe)	yes	no	

_____

OPERATIONS:			**Year**
Tonsils	yes	no	
Appendix	yes	no	
Gall bladder	yes	no	
Stomach	yes	no	
Breast	yes	no	
Uterus &\or ovary	yes	no	
Prostate	yes	no	
Hernia	yes	no	
Thyroid	yes	no	
Varicose veins	yes	no	
Haemorrhoids	yes	no	
Heart	yes	no	
Other (describe)	yes	no	

_____
_____

INJURIES:			Year
Head	yes	no	
Chest	yes	no	
Abdomen	yes	no	
Broken bones	yes	no	
Back	yes	no	
Other (describe)	yes	no	

_____
_____

DRUG REACTIONS:			Year
Penicillin	yes	no	
Sulpha	yes	no	
Foods	yes	no	
Cosmetics	yes	no	
Other drugs	yes	no	

(Describe)_____
_____

HOSPITALISATIONS:
Reason: Year
_____
_____
_____
_____
_____

X-RAYS & OTHER TESTS: Describe results:

Chest x-ray	yes	no	_____
Stomach x-ray	yes	no	_____
Bowel x-ray	yes	no	_____
Gallbladder x-ray	yes	no	_____
Kidney x-ray	yes	no	_____
Electrocardiogram	yes	no	_____
Other Tests that were abnormal:			_____
			_____
			_____
			_____

PLEASE LIST ALL YOUR MEDICATIONS BELOW OR ON OTHER SIDE OF PAGE.

FAMILY HISTORY -Has any blood relative had any of the following: circle 'yes' or 'no' -If so, what relationship:

Anemia	yes	no	_____
Bleeding tendency	yes	no	_____
Leukaemia	yes	no	_____
Repeated infections	yes	no	_____
Crippling infections	yes	no	_____
Heart disease	yes	no	_____
Chronic lung disease	yes	no	_____
Tuberculosis	yes	no	_____
High blood pressure	yes	no	_____
Kidney disease	yes	no	_____
Asthma	yes	no	_____
Severe allergies	yes	no	_____
Mental illness	yes	no	_____
Convulsions or fits	yes	no	_____
Migraine headaches	yes	no	_____
Diabetes	yes	no	_____
Low blood sugar	yes	no	_____
Obesity	yes	no	_____
Thyroid trouble	yes	no	_____
Peptic ulcer	yes	no	_____
Bowel disease	yes	no	_____
Cancer	yes	no	_____
Arthritis	yes	no	_____
Stroke	yes	no	_____
Gout	yes	no	_____
Birth defects	yes	no	_____
Other (describe)	yes	no	_____

_____

Family member:	**Age if living:**	**Health problems? Age of death if deceased.**
Grandparents:		
1.		
2.		
3.		
4.		
Father		
Mother		
Brothers/Sisters		
1.		
2.		
3.		
4.		
5.		
6.		

DESCRIPTION OF CURRENT SYMPTOMS & HEALTH PROBLEMS

HAVE YOU EVER HAD ANY OF THE PROBLEMS DESCRIBED BELOW? Circle 'Yes' Or 'No', And GIVE DETAILS if 'Yes'

GENERAL			GIVE DETAILS BELOW
Tired easily, feeling of weakness	yes	no	
Marked weight change	yes	no	
Night sweats	yes	no	
Persistent fever	yes	no	
Sensitivity to heat	yes	no	
Sensitivity to cold	yes	no	
SKIN			
Rashes	yes	no	
Change in colour	yes	no	
Change in hair	yes	no	
Change in nails	yes	no	
EYES			
Trouble seeing	yes	no	
Eye pain	yes	no	
Inflamed eyes	yes	no	
Double vision	yes	no	
Worn glasses	yes	no	
EARS			
Loss of hearing	yes	no	
Ringing in ears	yes	no	
Discharge	yes	no	
NOSE			
Loss of smell	yes	no	
Frequent colds	yes	no	
Obstruction	yes	no	
Sinus congestion	yes	no	
Excess discharge	yes	no	
Nose bleeds	yes	no	
MOUTH/ DENTAL			
Canker sores	yes	no	
Sore or bleeding gums	yes	no	
Sore tongue	yes	no	
Any silver/mercury fillings? How many?	yes	no	
Any root canals?	yes	no	
Other dental problems	yes	no	
THROAT			
Post nasal drainage	yes	no	
Soreness	yes	no	
Hoarseness	yes	no	
BREAST			
Lumps	yes	no	
Discharge	yes	no	
HEART&LUNGS			
Cough, persistent	yes	no	
Sputum (phlegm)	yes	no	
Bloody sputum	yes	no	
Wheezing	yes	no	
Chest pain or discomfort	yes	no	
Pain on breathing	yes	no	
Difficulty breathing	yes	no	
Swelling of ankles	yes	no	
Bluish fingers or lips	yes	no	
High blood pressure	yes	no	
Palpitations, irregular heart beat	yes	no	
Vein trouble	yes	no	

USE OF HEALTH PROFESSIONALS

Date of last complete medical exam_____

During the past year, how many visits have you made to each of the following :

____ Family doctor _____Psychiatrist

____ Specialist doctor _____ Other counsellor

____ Hospital emergency _____ Dentist

DIGESTIVE SYSTEM			GIVE DETAILS BELOW
Change in appetite	yes	no	
Difficulty swallowing	yes	no	
Heartburn	yes	no	
Abdominal discomfort	yes	no	
Belching, burping	yes	no	
Flatulence (excess farting)	yes	no	
Abdominal bloating	yes	no	
Nausea	yes	no	
Vomiting	yes	no	
Rectal bleeding	yes	no	
Tarry (black)stools	yes	no	
Dark urine	yes	no	
Jaundice (yellow skin)	yes	no	
Constipation	yes	no	
Need for laxatives	yes	no	
Diarrhoea	yes	no	
Haemorrhoids	yes	no	

BOWEL HABITS

Average frequency of bowel movements:_____

Longest time between bowel movements (e.g., if travelling or not well):

_____

Have you ever travelled in the tropics, or had traveller's diarrhoea?

If so, describe:

GENITOURINARY			
Frequent urination (day)	yes	no	
Frequent urination (night)	yes	no	
Feel need to urinate without much urine	yes	no	
Unable to hold urine	yes	no	
Pain or burning of urination	yes	no	
Blood in urine	yes	no	
JOINTS/BONES/MUSCLE			
Muscle cramps	yes	no	
Muscle weakness	yes	no	
Pain in joints	yes	no	
Swollen joints	yes	no	
Stiffness	yes	no	
Deformity of joints	yes	no	
NERVOUS SYSTEM			
Headaches	yes	no	
Dizziness	yes	no	
Fainting	yes	no	
Convulsions or fits	yes	no	
Nervousness, anxiety	yes	no	
Sleeplessness, insomnia	yes	no	
Depression	yes	no	
Memory loss	yes	no	
Change in sensation	yes	no	
Poor co-ordination	yes	no	
Weakness or paralysis	yes	no	
HORMONAL			
Thyroid trouble	yes	no	
Adrenal trouble	yes	no	
Cortisone treatment	yes	no	
Diabetes	yes	no	

GYNAECOLOGY

Started menstruating at age_____ or N/A_____

Interval between periods:_____days duration:_____days

Flow: light normal heavy Date of last period_____

Pain with periods? yes no mild severe

Problems with vaginal discharge: ___yes ___no ___in past, not now

Premenstrual symptoms: ___ yes ___ no.

Describe: Mood changes Weight gain Retain fluid Cravings

Abdominal symptoms Tender breasts Fatigue Other: _____

Have you ever used, or would you ever consider using, any of the following "alternative" methods of healing?

(Mark the applicable ones)

__Chiropractor __Massage therapist __Naturopath __Homeopath __Acupuncture__ other (please describe)

NUTRITION AND HEALTH

DIETARY HISTORY

Have your eating habits changed over the past 5 years? (Yes No) If so, describe the changes:

_____

Are you currently following a special diet? (Yes No) If so, describe what kind of diet:

How many meals per week do you skip? _____meals per week. **Which ones?** ___breakfast ___lunch ___supper

On the average, how many times per week to you eat the following kinds of foods?

_____ "Convenience" foods such as TV dinners, Kraft dinner, instant breakfast, canned dinners (stews, spaghetti, etc.), food mixes

_____ At fast food outlets (McDonald's, Tim Horton's, Col. Saunders, etc.) _____ Other restaurants

Who prepares most of your meals?_____

How often do you read labels while shopping in order to avoid unhealthy ingredients? _____ Rarely ____ Sometimes _____Often

Indicate your average food selections for each meal:

Breakfast_____

Lunch_____

Supper_____

Snacks_____

USE OF FOOD GROUPS:

PROTEIN FOODS: Circle the ones you use daily; underline the ones you use at least a few times each week:
Red meats/ chicken/turkey & other fowl/Fish/Eggs/ Milk products/ beans & soy products/ seeds & nuts

STARCHES: Circle the ones you use daily; underline the ones you use at least a few times each week:
Whole grain (brown) breads/ White or light brown breads/ potatoes/ white rice/ brown rice/ white pasta/whole grain pasta/ dry breakfast cereals/cooked breakfast cereals/ corn & corn products

VEGETABLES & FRUIT: Circle the ones you use daily:
Raw vegetables/salads/ starchy vegetables (squash, corn, root vegetables) Fresh fruit/ cooked, canned or dried fruit

SWEETS: Underline the ones you use at least a few times each week:
White or brown sugar/ corn syrup/ molasses/ maple syrup/ honey/ candy

FATS: Underline the ones that you use at least a few times a week:
Fried foods/ butter/ margarine/ cream/ gravies/ lard/ vegetable oil

What kind of vegetable oil do you usually use? _____

BEVERAGES: Circle the ones you use daily; underline the ones you use at least a few times each week:
Water/ black tea/ green tea/ herbal teas/coffee/ decaffeinated coffee/ colas/ other soft drinks/ diet soft drinks

Have you ever taken vitamins or food supplements? ___Yes ____No. If so, do you feel any better for taking them? ___Yes ____No

PLEASE LIST ON A SEPARATE PIECE OF PAPER A <u>COMPLETE</u> LIST OF ALL NUTRITIONAL SUPPLEMENTS YOU ARE TAKING REGULARLY, AND INCLUDE THIS WITH THE QUESTIONNAIRE. IF SOME OF THEM ARE A DEFINITE HELP TO YOU, INDICATE WHICH ONES.

Hidden food sensitivities are a <u>very</u> common factor in chronic illness. Some of the more common ones are listed below. Are there any of these foods that have given you have bad reaction, mild or severe, either now or in the past (such as indigestion, headache, rashes, swelling, changes in your mood, wheezing, etc.)? If so, indicate which foods below, and describe briefly the reaction you get:

____ artificial flavourings, colourings, or other food additives
____ milk, or milk products
____old cheeses, or vinegar, or pickled products
____ beer, wine, or alcohol
____ coffee or tea
____ sugar or highly sweetened foods
____ chocolate or cocoa
____ wheat or any other grains (specify)
____ bread (especially when fresh), or other baked goods
____ eggs
____ fish
____ shellfish
____ corn
____ nuts, especially peanuts or peanut products
____ tomatoes, or tomato products
____ oranges or grapefruit
____ any other foods:_____

Food cravings can be a sign of hidden food sensitivity. Look at the list of foods above, and decide whether there are any of them which you <u>crave</u>, or that you would find <u>very difficult to give up eating</u>. If so, list these below:

ENVIRONMENTAL AND TOXIC INFLUENCES ON HEALTH

Environmental effects on health can be very significant. Please indicate whether you have noticed an influence from any of the following environmental factors. If so, please indicate by underlining the appropriate items, and **describe your reaction** beside them. Some of these factors may be significant even if you are not aware of any obvious reaction to them. If you have had in the past **significant exposures** to mould, chemicals, or electromagnetic fields, (either at home or work) please also **circle** these below.

ENVIRONMENTAL FACTOR: (underline the ones you react to)	**DESCRIBE YOUR REACTION OR SIGNIFICANT EXPOSURE NEXT TO THE FACTORS SELECTED.**
DUST	
House dust	
Other kind of dusts (road, wood, etc.)	
MOULDS	
Damp basements	
Old buildings/water damaged buildings	
Old barns, Old hay/straw	
Air conditioners	
Other:	
ANIMALS	
Dog/cat/horse/ other (describe)	
FEATHERS	
Feather pillows	
Birds	
POLLENS	
Trees	
Grasses	
Rag weed	
Country air	
Other pollens:	
SMOKE	
Wood smoke	
Tobacco smoke	
Other smoke:	
CHEMICALS	
Engine exhaust, traffic	
Cleaning solutions	
Paint fumes/ refinishing fumes	
Pesticide/herbicide sprays	
Perfumes/scented products	
Newsprint	
City air	
Indoor air in general	
Toxic metals	
Swimming pools	
Other chemicals:	
WEATHER	
Hot, muggy weather	
Damp or muggy weather	
Spring or fall weather	
Cold weather	
Approaching storms	
Change in location	
Other climactic effects:	
ELECTROMAGNETIC FIELDS	
Fluorescent lighting	
Computer monitors	
High-voltage transmission lines	
X-ray or nuclear radiation	
Other electromagnetic fields:	
DRUGS	
Aspirin, or other pain relievers	
Antibiotics	
Others (please describe)	

MORE ON ENVIRONMENT AND HEALTH

1. Have you ever had allergy tests? _____yes _____no If so, what did they show? _____

2. Have you ever had allergy injections? _____yes _____no If so, to what? _____

If so, did the allergy injections help you (yes/no), or make your symptoms worse (yes/no)?

3. Approximately when was your home built? _____

4. What kind(s) of heating system does your home have?___ oil ___natural gas
__electric (forced air) __ electric (baseboard) ___wood ___other:_____

5. What kinds of flooring does your home have in the bedrooms? ___Carpet __Wood ___Linoleum __Other

6. Does your home have a damp or musty basement, or visible mould around windows or elsewhere?
___ Yes ___No If yes, please elaborate:

_____

7. In your home, is there a: smoke detector? carbon monoxide detector? fire extinguisher? first-aid kit?

8. When in a car, how often do you use a safety belt?
___Rarely ___Sometimes ___Always, or almost always

USE OF DRUGS AND CHEMICALS

Heaviest use of alcohol in the past? _____drinks per day/week/month
Current use of alcohol? __yes __no. _____drinks per day/week/month
Heaviest use of cigarettes in the past? __yes __no. _____packs per day/week/month
Current use of cigarettes? __yes __no. _____packs per day/week/month
Other forms of tobacco consistently used (now or in the past): ____pipe ____cigar
Past use of marihuana? __yes __no . ____times per day/week/month
Current use of marihuana? __yes __no . ____times per day/week/month
Past use of 'recreational' or 'street' drugs? __yes __no . ____times per day/week/month
Current use of 'recreational' or 'street' drugs? __yes __no . ____times per day/week/month
Use of over-the-counter medications on a regular basis? __yes __no Circle which ones below:
Aspirin-Tylenol-Other pain relievers-Cough/cold remedies-Antihistamines-Laxatives-Other: _____

PHYSICAL ACTIVITY AND HEALTH

1. ON THE AVERAGE, HOW MUCH PHYSICAL EXERCISE YOU GET EACH DAY?

___ **None, or very little** (less than 1/2 mile walking, or less than ten flights of stairs)

___ **Some** (1/2 -1 1/2 miles walking or 10-30 flights of stairs or daily activities involving some physical activity such as: raising young children, scrubbing floors, gardening, or work which involves being on your feet most of the time)

___ **Fairly active** (over 30 flights of stairs or 1 1/2 -3 miles of walking or daily activities involving fairly active physical effort such as construction work, farming, moving heavy objects by hand, etc.)

___ **Very active** (over three miles of walking or daily hard physical labour, etc.)

2. DESCRIBE ANY REGULAR, VIGOROUS PHYSICAL ACTIVITY YOU DO. (Vigorous enough to make your heart pound, your breathing deep, and bring on sweating: such as: sports, running, heavy manual labour)

ACTIVITY:_____

DONE FOR: _____ minutes/hours, _____times per week

3. WHAT, IF ANY, FACTORS MAKE IT DIFFICULT FOR YOU TO KEEP PHYSICALLY ACTIVE?

___ Current illness or general condition
___ Lack of time to exercise
___ Lack of facilities
___ Other (describe): _____

4. ARE YOU OUT OF BREATH AFTER WALKING UP A FLIGHT OF STAIRS? ___ Yes ___No

5. HOW FAR CAN YOU WALK WITHOUT HAVING TO STOP TO REST?_____

6. HOW FAR CAN YOU RUN WITHOUT HAVING TO STOP TO REST? _____

LOW BLOOD SUGAR QUESTIONNAIRE

Low blood sugar (hypoglycaemia) is a common problem affecting mood and energy, yet it frequently goes unrecognised.

FOR EACH QUESTION PUT AN 'X' IN THE APPROPRIATE COLUMN ON THE RIGHT→	RARELY	SOME TIMES	OFTEN
1. Do you crave sweets?			
2. Do you eat sweets every day?			
3. Did you eat a lot of sweets as a child?			
4. Do you have coffee or tea or cola every day?			
5. You find it difficult to go without sweets?			
6. Do you find it difficult to go without coffee or tea?			
7. Do you feel better if you eat between meals?			
8. If your meals are late, do you feel weak, shaky, sick, irritable or tired?			
9. Do get a headache if you do not eat?			
10. Do you get ravenously hungry if you do not eat?			
11. Do you get sweaty if you go too long without eating?			
12. If you get light headed or trembling, does food or sweets make you feel better?			
13. If you feel tired does food or sweets make you feel more energetic?			
14. Do you use sweets or coffee or tea to make you feel less tired?			
15. If you get irritable, does eating make your mood improve?			
16. Do you feel tired or sleepy after meals?			
17. Do you feel tired or sleepy after a large starchy meal or a lot of sweets?			
18. Do you ever wake-up at night hungry?			
19. Do you ever fall asleep while sitting still?			
20. Does your heart ever pound, or go fast, or skip beats?			
21. Do you feel frightened or tearful for little or no reason?			
22. Do you feel cranky, irritable, sad or miserable for little or no reason?			
23. Do you get upset or worried about little things?			
TOTAL THE NUMBER OF RESPONSES IN EACH GROUP FOR THE 23 QUESTIONS ABOVE →			

SOME ADDITIONAL QUESTIONS:	**YES**	**NO**
1. Is there diabetes or low blood sugar in your family?		
2. Is there a history of alcoholism in your family?		
3. Have you ever been a heavy drinker?		
4. Do you have allergies? (Eczema, hay fever, asthma, etc.)		

5. How many cups per day do you have of the following: coffee ____, black tea____, cola____?

6. Who are your closest blood relatives who have (or have had) problems with alcohol, or have been prone to excessive drinking?

__ Mother ___ Father __Sister or brother __Others(Describe)_____

7. Have you ever had a blood sugar test? ___ Yes ___ No

If so, what were the results? _____ Normal _____ Abnormal _____ Don't know

CANDIDA QUESTIONNAIRE for CHILDREN

Yeast overgrowth in the intestinal tract is a common problem affecting mood, energy, and resistance to infection, yet it often goes unrecognised. Following is a list of points that suggest a role for this in your child's health:

FOR EACH QUESTION, CIRCLE THE NUMBER IN THE COLUMN THAT CORRESPONDS TO THE CHILD'S DEGREE OF SYMPTOMS: MILD, MODERATE, OR SEVERE	POINT SCORE		
	MILD	MODERATE	SEVERE or PERSISTENT
1. During the 2 years before your child was born, was the mother bothered by recurrent vaginitis, menstrual irregularities, premenstrual tension, fatigue, headaches, depression, digestive disorders, or "feeling bad all over"?	25	30	35
2. Was your child bothered by thrush?	10	15	20
3. Was your child bothered by frequent diaper rashes in infancy?	10	15	20
4. During infancy, was your child bothered by colic and irritability lasting over 3 months?	10	15	20
5. Are his or her symptoms worse on damp days or in damp or moldy places?	10	20	30
6. Has your child been bothered by recurrent or persistent "athlete's foot" or chronic fungus infections of skin or nails?	20	30	40
7. Has your child been bothered by recurrent hives, eczema or other skin problems?	5	10	15
8. Has your child received 4 or more courses of antibiotic drugs during the past year? Or has the child received continuous "preventive" courses of antibiotics?		60	
9. Has your child received 8 or more courses of antibiotics during the past three years?		30	
10. Has your child experienced recurrent ear problems?	5	10	15
11. Has your child had tubes inserted in his ears?		10	
12. Has your child been labeled "hyperactive"?	10	15	20
13. Is your child bothered by learning problems?	5	10	15
14. Does your child have a short attention span?	5	10	15
15. Is your child persistently durable, unhappy, and hard to please?	5	10	15
16. As your child been bothered by persistent or recurrent digestive problems, including constipation, diarrhea, bloating, or excessive gas?	10	20	30
17. As he been bothered by persistent nasal congestion, cough, and/or wheezing?	5	10	15
18. Is your child unusually tired or unhappy or depressed?	5	10	20
19. Has your child been bothered by recurrent headaches, abdominal pain, or muscle aches?	10	15	20
20. Does your child crave sweets?	5	10	15
21. Do you feel that your child isn't well, yet diagnostic tests have not yet revealed the cause?	5	10	15
TOTAL SCORE →			

SCORE RESULTS: 60 or more → Possible health effect from yeast overgrowth in the intestine
100 or more → Probable health effect from yeast overgrowth in the intestine
140 or more → Almost certain health effect from yeast overgrowth in the intestine