

Pre-visit questionnaire for Dr. Cherry

Patient's name	Nickname
What is your main concern about your child's GI health?	
Additional or secondary concerns (please check if any):	
<input type="checkbox"/> Abdominal pain <input type="checkbox"/> Colic <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Blood in stool <input type="checkbox"/> Gastroesophageal reflux <input type="checkbox"/> Abnormal lab tests: <input type="checkbox"/> Family history: <input type="checkbox"/> Other:	<input type="checkbox"/> Picky eating <input type="checkbox"/> Food sensitivities <input type="checkbox"/> Burping <input type="checkbox"/> Flatulence (farting) <input type="checkbox"/> Abdominal distention <input type="checkbox"/> Growing too slowly <input type="checkbox"/> Gaining weight too quickly <input type="checkbox"/> Losing weight
Was your child born preterm/premature?	<input type="checkbox"/> yes How premature? _____ <input type="checkbox"/> no
Does your child have any of the following neurological issues (known or suspected)?	<input type="checkbox"/> ADD or ADHD <input type="checkbox"/> autism spectrum disorder <input type="checkbox"/> tic disorder <input type="checkbox"/> seizure disorder <input type="checkbox"/> other
Does your child have any of the following behavioral or psychiatric issues (known or suspected)?	<input type="checkbox"/> sensory integration disorder <input type="checkbox"/> cerebral palsy <input type="checkbox"/> speech or language delay <input type="checkbox"/> other developmental delay
<input type="checkbox"/> anxiety disorder <input type="checkbox"/> mood disorder (such as depression) <input type="checkbox"/> eating disorder <input type="checkbox"/> other	<input type="checkbox"/> OCD (obsessive-compulsive disorder) <input type="checkbox"/> bipolar disorder

<p>Is your child on any particular diet or eating plan?</p> <p><input type="checkbox"/> no restrictions</p> <p><input type="checkbox"/> vegetarian</p> <p><input type="checkbox"/> vegan</p> <p><input type="checkbox"/> other</p>	<p><input type="checkbox"/> gluten free</p> <p><input type="checkbox"/> lactose free</p> <p><input type="checkbox"/> dairy free</p>
<p>Is there any family history of:</p> <p><input type="checkbox"/> food allergies? <i>Which family member??</i> _____</p> <p><input type="checkbox"/> asthma?</p> <p><input type="checkbox"/> eczema?</p> <p><input type="checkbox"/> eosinophilic esophagitis?</p> <p><input type="checkbox"/> severe gastroesophageal reflux?</p> <p><input type="checkbox"/> celiac disease?</p> <p><input type="checkbox"/> H. pylori infection?</p> <p><input type="checkbox"/> irritable bowel syndrome (IBS)?</p> <p><input type="checkbox"/> inflammatory bowel disease (IBD)?</p> <p style="padding-left: 20px;"><input type="checkbox"/> Crohn disease</p> <p style="padding-left: 20px;"><input type="checkbox"/> Ulcerative colitis</p> <p style="padding-left: 20px;"><input type="checkbox"/> uncertain</p> <p><input type="checkbox"/> colon cancer?</p> <p><input type="checkbox"/> liver disease or cirrhosis?</p> <p><input type="checkbox"/> pancreatitis?</p> <p><input type="checkbox"/> other GI disorders? <i>What kind and who has it?</i> _____</p> <p><input type="checkbox"/> thyroid disease?</p> <p><input type="checkbox"/> childhood (Type I) diabetes?</p> <p><input type="checkbox"/> rheumatoid arthritis?</p> <p><input type="checkbox"/> psoriasis?</p> <p><input type="checkbox"/> other chronic health conditions: <i>What kind and who has it?</i> _____</p>	
<p>What is your child's current grade in school?</p>	
<p>Which school does your child attend?</p>	
<p>Which activities does your child enjoy outside of school?</p>	
<p>What are the main sources of stress in your child's life?</p>	
<p>What are your child's strengths?</p>	