Health Screening Questionnaire

1. Has your child ever had a bladder or kidney infection?  □ Yes □ No

2. Does your child complain of pain or burning when urinating?  □ Yes □ No

3. Does your child urinate more than 9 times a day?  □ Yes □ No

4. Does your child hold back urine for extended periods of time (ie, more than 8 hours)?  □ Yes □ No

5. Does your child have daytime wetting? (This includes having damp underpants throughout the day.)  □ Yes □ No

6. Has your child recently begun wetting the bed after 6 months or more of being dry at night?  □ Yes □ No

7. Does your child have trouble with his urinary stream? (This includes dribbling, having a weak stream, or having to push hard to start urination.)  □ Yes □ No

8. Does your child have damp underpants after going to the bathroom?  □ Yes □ No
9. Does your child wake up more than once a night to drink water? □ Yes □ No
10. Does your child have a problem with abdominal pain or chronic diarrhea? □ Yes □ No
11. Does your child hold in bowel movements? □ Yes □ No
12. Does your child ever soil underpants with stool? □ Yes □ No
13. Has your child experienced a recent history of mood swings or other emotional problems? □ Yes □ No
14. Does your child snore heavily at night in such a way that your child sometimes stops breathing or struggles to breathe? □ Yes □ No
15. Does your child have insomnia, sleepwalking, or night terrors? □ Yes □ No

If you answered yes to any of these questions, do not begin the program without seeing your doctor.