

APPENDIX B

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

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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.