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.