

Name _____ Date _____ DOB _____

Nutrition Form

Please fill out this form before coming to see the nutritionist. Provide as much information as you can.

Food allergies, avoidances, sensitivities

Food	Reaction or reason for avoidance	Approx date avoidance began

Appetite Circle those that apply. My child's appetite is:

good (eats 75-100% of foods served) fair(eats 50-75% foods served) or poor (eats <50% foods served)

Past medical History

Medical condition	Length of time with condition	Dietary restrictions

Has your child ever needed speech therapy? No Yes please explain diagnosis, special diet and therapies.

Has your child been to a dentist? No Yes Explain treatments, procedures, therapies.

Do you have enough resources to obtain food needed? Yes No Explain limitations. _____

Does your ethnical or cultural background influence your child's diet? No Yes Explain _____

Gastrointestinal Issues. Does your child have reflux, bloating, gas, diarrhea, constipation, nausea, vomiting, abdominal distention? Explain _____

Any medications or home remedieies given for above issues? _____

Who does the food shopping in your household? _____ Who prepares meals? _____

How many meals does your family eat together daily? _____ Does your child eat/snack in front of TV/computer? _____

How often does your child eat fast food? _____ What is your childs favorite fast food? _____

How often does your child eat candy or sweets such as cookies, cake, icecream? _____

Does your child eat or lick non food items? Dirt Clay Paint chips Wood Ice Plaster
 Chalk Utensils Windows or other cool surfaces Hair

Is your child physically active? Yes No How Often does your child play vigorously? _____

Does your child fall asleep easily? Yes No Does your child stay asleep? Wake often? Wake up crying or laughing?

Does your child have any neurological diagnosis or other disabilities? _____

Has your child had any recent significant weight loss or weight gain? No Yes ____ lb loss gain ____ weeks ____ months

Does your child drink water? Yes No From what source? Tap Bottle Well Filter _____

Medications/Supplements/Vitamins

Med/Vitamin/Supplement	Condition	Have you seen improvement?

Family History Please list all of the conditions known in the child’s family. Include chronic diseases, GI disorders, allergies, asthma, cancers, etc.

Condition(s)	Relationship to child

Please provide a description of what your child eats or drinks on a typical day

Breakfast	Amount eaten	How prepared	Where eaten
Lunch			
Snack			
Dinner			
Snack			