Pediatric Nutrition Questionnaire

Patient Name_______________________________________ DOB _______ Race________________

Please specify any religious/cultural or personal health beliefs that you would like us to consider as we help you develop your child’s nutrition care plan:
________________________________________________________________________

What language do you prefer using in discussing your child’s health care? ❑ English ❑ Other: ____________________________________________________________

Parent/Guardian Information:

Name________________________________________Relationship_______________________ Occupation________________________

Phone: Home________Work_________________________Cell________

Name________________________________________Relationship_______________________ Occupation________________________

Phone: Home________Work_________________________Cell________

Child lives with (please give name, age, and relationship):
________________________________________________________________________

Child’s school or daycare_________________________Grade_________Hours at school________

Does your child have any food or medication allergies? ❑ No ❑ Yes If yes, please specify:__________________________________________________________

Does your child or any other family member have any of the following health problems?

Anxiety/depression ❑ No ❑ Yes If yes, who?
Asthma ❑ No ❑ Yes If yes, who?
Celiac disease ❑ No ❑ Yes If yes, who?
Constipation/diarrhea ❑ No ❑ Yes If yes, who?
Diabetes ❑ No ❑ Yes If yes, who?
Heart disease ❑ No ❑ Yes If yes, who?
High cholesterol ❑ No ❑ Yes If yes, who?
High blood pressure ❑ No ❑ Yes If yes, who?
Kidney disease ❑ No ❑ Yes If yes, who?

Other medical information that may help us better know your child: ____________________________________________________________

Social History:

Please describe any personal or family events or concerns that we should be aware of, such as divorce, moving, school problems.
________________________________________________________________________

Does your child use alcohol, tobacco, or recreational drugs? ❑ No ❑ Yes If yes, please explain ________________________________

Are you or your child in a situation in which you fear for your safety? ❑ No ❑ Yes

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Patient Name ______________________________________________________ DOB _______________________.

Exercise and Activity:
List your child’s sports or extracurricular activities: _____________________________________________________________
List any physical limitations of your child: __________________________________________________________________

Growth History:
Child’s birth weight ___________ Child’s birth length ___________
Mother’s weight ___________ Mother’s height ___________ Father’s weight ___________ Father’s height ___________
Please describe any changes or concerns about your child’s growth pattern: ____________________________________________
_________________________________________________________________________________________________________

Do you have any concerns about the food choices of your child or family? ❑ No ❑ Yes If yes, please explain ______________
_________________________________________________________________________________________________________

Are you or any members of your family currently on any type of meal plan or diet? ❑ No ❑ Yes If yes, please describe __________________________
_________________________________________________________________________________________________________

Who does most of the cooking and grocery shopping in your home? ________________________________
Are there any food practices that we should know about? (such as vegetarian, no pork) ________________________________

Child’s favorite beverages: ________________________________________________________________

Usual Daily Schedule:

<table>
<thead>
<tr>
<th>Where is the child usually?</th>
<th>Sit down family meal or eaten “on the run”?</th>
<th>Typical Foods</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breakfast</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Time ______</td>
<td>______</td>
<td>______</td>
</tr>
<tr>
<td>Lunch</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Time ______</td>
<td>______</td>
<td>______</td>
</tr>
<tr>
<td>Dinner</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Time ______</td>
<td>______</td>
<td>______</td>
</tr>
</tbody>
</table>

Snacks: What? ___________________________ When __________________________________________

Signature of person filling out form __________________________________________________________

Relationship to patient ___________________________ Date ____________________________

DIETITIAN’S SIGNATURE ___________________________ DATE/TIME ____________________________

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