Nutrition Intake-Child

Child's Name________________________ Height____________ Weight_________________

Address_____________________________ Date of birth_______ Age____________________

____

Parent Name(s)

____

Referred by_______________________________ Phone: Home________________________

Phone Work: _____________________________ Cell: _________________________________

Email: ___________________________________

Health Objectives:

____

____

____

____

____

____

____

____

What would you like to learn and gain from working with a nutrition educator? (i.e. how foods affect an ailment, understanding of how the body works, lifestyle improvement, etc.)

____

____

____

____

____

____

____

____

____

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Last Name__________________

Health Background

I need to know a great deal about your child's body, health, and life. Please tell me what you think I should know about your situation. Please include any research/internet searches that you have already done. Use as much space as needed.

Describe any current health conditions that you are interested in addressing (onset, duration, frequency, etc):

____
____
____
____
____
____
____
____
____
____
____
____
____
____

How have you addressed these conditions (currently and in the past) i.e. doctor, self-care, nutrition, acupuncture and what has been the impact (positive or negative)?

____
____
____
____
____
____
____

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Child's Health History

What practitioners are you currently seeing? May I contact them with your permission?

Name Specialty/condition Phone Permission

____

____

____

____

____

____

____

List medications. Please include condition being treated i.e. Zoloft for depression

____

____

____

____

____

____

____

List supplements. Please include dosage i.e. Vitamin E 400 IU

____

____

____

____

____

____

____

Last Name__________________

Describe your child's health history (generally healthy, frequently sick ear infections, colic, etc.)

____
____
____
____
____
____

Antibiotics

Describe how frequently your child has taken antibiotics over the course of their life- include long term use for acne, short term courses for ear infections, etc.

____
____
____
____
____
____

Does your child have/get yeast overgrowth (yeast infections, nail fungus, athlete's foot) now or in past?

Do they have the following feelings/symptoms, if so, how often?

Fatigue____
____

Allergies/runny nose____
____

Eczema, rashes or skin conditions____
____

Depression____
____

Anxiety____
____

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Digestion and Elimination

Does your child have frequent gas or bloating?	Y	N
Does gas have a strong odor?	Y	N
Does your child tend to have diarrhea or soft, unformed stool?	Y	N
Does your child tend to have constipation?	Y	N
Does your child have heartburn or acid reflux?	Y	N
Does your child take antacids or acid blockers?	Y	N

Describe any other digestive issues:

____
____
____
____
____

How frequently does your child have a bowel movement?

____

What is consistency of stool?

____

Formed like a brown banana?

____

Unformed, soft or ribbon like?

____

Small balls formed into banana or “rabbit pellets”?

____

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Dietary History

Does your child have any food cravings i.e. sugar, carbs, fats? If yes, please list which foods or types of foods.

____
____
____
____
____

Does your child have any known food allergies or sensitivities? Y N

Does your child get unexplained headaches______, diarrhea_____, pain_____, fuzzy thinking____, fatigue_____?

Does your child consume: coffee/caffeine___ diet sodas____ trans fats_____ regular soda_______ MSG_____

How much water do they drink per day?______________________ What type? Bottled, tap, filtered__________________

Describe dieting history or eating disorders: age, yo-yo dieting, calorie restriction, weight gain

____
____
____
____

Has your child been diagnosed or do you believe she/he may have hypoglycemia?
Y N

Do they need to eat frequently?
Y N

Do they get irritable, nervous, dizzy headaches, when they go too long without eating?
Y N

Are they a picky eater?
Y N

Is the issue texture________ or taste _____________ both ________________

Last Name___________________

What foods will they eat?

____
____
____
____
____

Family History (indicate family member i.e. parent, child, sibling). Please use back of page if necessary

Illness **Family Member**

Diabetes/
hypoglycemia____
____

Heart
disease____
____

Cancer____
____

Obesity____
____

Depression____
____

Anxiety____
____

ADHD____
____

Autism____
____

LD____
____

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Illness	**Family Member**
Hyperactivity	
Tics	
Tourette's syndrome	
Colitis/ IBS	
Arthritis	
Autoimmune disorder	
Migraines/ Headaches	
Alcoholism	
Bipolar Disorder	
Schizophrenia	
Other	

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Toxic Exposure

Has your child had exposure to any toxins (pesticides, chemicals, heavy metals, plastics, inhaled, chemicals, industrial chemicals) that you are aware of at your home or office? Think about where you live and products you may have used. i.e. living on a golf course exposes one to pesticides and herbicides, recent home or school renovations expose one to paint, adhesives, buying a new car, etc.

____
____
____
____

Has your child received any vaccinations including the flu shot in the last few years?

____
____

Are there any chemicals or smells that they are sensitive to? For example, do they get a headache or nauseous when they smell grandma's perfume or after you've cleaned your home?

____
____
____
____

Have you recently remodeled or plan to remodel your home? What did you have done?

____
____
____
____

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Has your child stayed in other places that were recently remodeled? i.e. school, grandparent's, a friend's home that he/she spends a lot of time at?

____
____
____
____

Has your home or your child's school had a problem with mold or mildew? Y N

Do you live in a damp or humid environment? Y N

Does your child consume or have exposure to the following. If so, explain frequency:

Artificial sweeteners____
____

Fluoridated water____
____

Chemical cleaning supplies____
____

Perfume/ fragrance____
____

Fabric softener or drier sheets____
____

Tobacco____
____

Alcohol/recreational drugs____
____

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Lifestyle

Sleep

What time does your child go to sleep?____

How many hours does your child typically get per night?___________________________

Does your child wake during the night?____

Does your child fall back asleep easily?____

Does your child sleep in his/her bed all night?

____

If not, where does s/he sleep?____

Does your child have difficulty getting up in the morning?

Nighttime Eating

Do you or your child eat in the middle of the night? Y N

How many times per week?______________

Are you or your child aware of eating at night at the time? Y N

Do you or your child wake hungry in the middle of the night and go eat? Y N

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Exercise

Is your child capable of regular activity? If no, you may skip this section.

Does your child exercise regularly? Y N

What sort of exercise does your child do?

___

How often?

___

For how long? ___

If your child is capable but inactive, is he/she open to adding activity to his/her schedule? Y N

If they are capable, are you open to exposing your child to various activities? Y N

Screen Time

How many hours per day does your child play on an IPOD, watch t.v., or work/play on a computer?___________________________________

Community

Does your child have friends? Y N

Does your child prefer to be alone? Y N

Does your child participate in any community activities? Please list. Example: church youth group, scouting, summer camps

___

___

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Food/Mood Record

1. Please write out your child's daily diet. Fill out a diet record for at least two days, preferably one week day and one weekend day. Include portion size and any supplements or medications. Include time of day.

2. Additionally, record any symptoms you observe or your child describes during or after eating such as drowsy, irritable, energized.

   See Below.

Last Name________________________

Food/Mood Record

Meal	Time	Food/Supplement	Mood/Energy/ Symptom
Example	9:00	1 cup of Capn Crunch, ½ cup of cow's milk, 8 oz. of O.J. 1 Flintstone multi	Right after eating had runny nose, energized
Breakfast			
Snack			
Lunch			
Snack			
Dinner			
Night time eating			

How much and what type of beverages does your child/you drink each day?

Water

Soft Drinks (sugar or diet)

Milk

Juice drinks

Fruit juices

Other

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