Pediatric Intake Form– nutrition

General Information:

Child's Name: ___________________________ Contact Name:____________________

Contact's relationship with the child: ____

E-mail of contact person: ____

Phone Number of contact person: ____

Address of contact person: ____

Child's age and date of birth: ____

Please state your primary objective(s) for seeking nutritional advice regarding your child:
____
____
____

Have any medical (conventional or alternative) interventions been employed or suggested for the issue(s) you are seeing a nutritionist about (medication, surgery, testing, homeopathy, diet etc)? If yes, what?
____
____
____

Child's Medical History:

Were medications used (like morphine, epidural, tylenol petocin, naproxen etc) **during pregnancy, during birth or in the first 3 months after the birth**? If yes, which one(s)
____
____

Is the child currently on any medication or supplements? If so what? ________________
____
____

Was the birth process vaginal or C-section? _____________

Was the child breastfed? _____ If yes, for how long? ___________

At what age did the child start solid food? ____________________________________

Did/does your child ever experience any of the following:

_____ Diaper rash
_____ Thrush
_____ Eczema
_____Constipation (less than one bowel movement every day)
_____Wheezing, chronic coughing or any other respiratory issue
_____ Diagnosed asthma
_____Diarrhea (very soft or watery stools)
_____Recurrent colds (sick all the time)
_____Recurrent ear infections
_____Chronic congestion
_____Mood swings, temper tantrums
_____Hyperactivity
_____Urinary tract or bladder infections

How long was gestation (in weeks)? _________________

Please indicate what, if any, food allergies/sensitivities you think your child has:
____
____

What are the symptoms of the allergies/sensitivities?
____
____

Has the child ever been tested for allergies or sensitivities? If yes, what type of test and what were the results?
____
____
____

Typical Bowel Movements:

Frequency (how often per day): ____
Color: __green ___yellow ____brown ____black
Consistency: ____soft _____hard ____watery ____ sticky
Mucus or blood? (circle)

Does your child have any cavities or other tooth problems?________________________

Has your child required orthodontics? ____

Medical History of Parents:

Did the mother take any **supplements or medications** on a regular basis during the pregnancy and/or during breastfeeding? If yes, what?

____
____
____

Does the mother or father have any allergies (food, environmental, medication…etc)? If yes, what are they?
Mother ____
Father: ____

Were there any pregnancies before this one? If so, how many years are there between children?____

Did the mother suffer from any of the following **during or before** pregnancy
- ____ yeast infections
- ____ candida
- ____ eczema
- ____ allergies
- ____ asthma
- ____ constipation, diarrhea or bloating
- ____ Irritable Bowel Syndrome
- ____ hypoglycemia, metabolic syndrome, or diabetes (including gestational)
- ____ excessive stress or trauma
- ____ anemia

Was the mother given antibiotics for GBS during the birth? Y_____ N____

Child's Typical Eating Patters

Indicate approximate times and preferred or typical foods:

Main meals:____

Snacks: ____

Beverages: ____

Any foods particularly avoided: ____

Any foods particularly craved: ____

How often per week does the child eat with at least 1 parent?
Breakfast: ______________
Lunch: _________________

Dinner: _______________

Do you coax your child to finish food? (Yes, No)

Would you consider your child to be a "picky" eater? ______________________

Does your child eat the same foods as the rest of the family? ______________________

Is there anything else about the child's eating pattern that concerns you?

In general, how would you characterize your meal times (circle all that apply)?
Easy Hectic Enjoyable Social Battles Stressful

Child's Social Patters (if applicable):
What grade is your child in? ______________

Describe your child's behavior at school ____

Describe your child's behavior at home ____

What are your child's favorite activities or interests? ______________________________

How much time does your child spend (per day) at the TV or computer? _____________

How often does your child have play time outside? ____________________

Is your child frequently exposed to second hand smoke? _________________

Do you have any pets in the home? ______________________

Has the child experienced any significant emotional or physical trauma? _____________

Does the child live with both parents? Please explain the child's living situation:

Is there anything regarding your child's social patterns that concerns you?

Please indicate if there is anything else you feel is pertinent regarding your child’s health that has not been covered: