COASTAL
FAMILY NUTRITION

Nutrition History

Name _____ Birth date_____ Age _____

Address _____

Telephone number/s _____

Email _____

Primary Care Physician _____

Health Insurance _____

Policy/group number_____

Subscriber_____ DOB of subscriber_____

Referred by _____

What concerns do you have about your child's diet?

How can I help you? What kind of support and information are you looking for?

9/2017

230 Lafayette Road, Suite 13A, Portsmouth, NH 03801 | 603-674-2479 phone **| 603-590-7471** fax

CoastalFamilyNutrition.com | Karen@CoastalFamilyNutrition.com

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Describe your child's physical activity.

How much time does your child spend outside per day?

How many minutes per day is your child sitting in front of a screen?

How many hours of sleep does your child get?

Does your child experience constipation, diarrhea, loose stool, heart burn, gas or bloating? Difficulty swallowing?

List foods that your child is allergic or digestively sensitive to and their reaction:

Height _____ Current Weight _____

List medications, vitamin, mineral and herbal supplements that he/she is taking:

_____

_____

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Briefly describe your child's health history and approximate date of diagnosis:

_____

_____

List significant diseases in your child's family's health history:

How would you describe your child's appetite?

Are there any foods or textures that your child dislikes?

As a family, how often do you eat our and where?

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