Nutrition History Form

Patient Name: ___________________________________ Date of Birth: ____________ Age: _________

Parent/Guardian name/s: ____

Address: ____

Telephone number/s: ____

Email: ____

Please check only if you **do not** wish to receive our email newsletter □

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

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

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____

Describe your child's physical activity.

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How much time does your child spend outside per day?

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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?

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

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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:

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

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How would you describe your child's appetite?

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Are there any foods or textures that your child dislikes?

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

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