Pediatric Medical Nutrition Therapy Intake

Please take the time to answer every question carefully. This provides valuable information on your child's individual case and allows for an effective holistic assessment. All questions are pertinent to the goal of designing a therapeutic nutrition care plan to best suit your child's unique needs.

General Information

Child's Name:______________________________ Address: ___________________________________

Age: __________ Date of birth:__________ ___________________________________

Phone: ___________________________________ ___________________________________

Parent/Caregiver's name(s): ____

Parent's Marital Status: Single Married Divorced Separated Widowed

Parent's Occupation: ____

Siblings: ________Brother(s) Their age(s) ______ _____Sister(s) Their age(s)________

Grade in School: ___________________________ Name of School: ___________________________

Who prepares meals? ______________________ Average hours of sleep per night:_____________

Name of primary care physician: ____

Name of Insurance: ________________________ Who is the primary insured? ________________

Medical History

Current Height ______________________________ Current Weight ______________________________

Growth History: ____

Are you concerned with your child's weight? Yes No

Are you concerned with your own weight? Yes No

Is your child concerned with his/her weight? Yes No

Mother's Height: ___________________________ Father's Height: ____________________________

Child's Birth Weight: ________________________ Breast Fed? Yes No How long? __________

Bottle Fed? Yes No How long? _________________________________

At what age were foods first introduced? ____

Food allergies/intolerances as an infant/toddler?____

Normal Pregnancy/Delivery? Yes No If No, please explain:_______________________

____

Normal growth & development? Yes No

List any complications: ____

____

Please list all medications that your child currently takes:

Prescription:____

____

Non-prescription: ______________________________

Vitamins: ______________________________

Herbal or other supplements: ______________________________

____

Please indicate whether your child or a family member have/had any of the following conditions:

Disease/Condition	***Child***	***Family Member***	***Relationship***	***Treatment***
Diabetes			____________	____________
Liver disease			____________	____________
Cancer			____________	____________
Orthopedic disorder			____________	____________
Heart Disease			____________	____________
High cholesterol			____________	____________
High blood pressure			____________	____________
Kidney disease			____________	____________
Stomach/intestinal disorder			____________	____________
Polycystic ovarian syndrome			____________	____________
Depression			____________	____________
Chronic stress or anxiety			____________	____________
Osteoporosis			____________	____________
Mental Health Issues			____________	____________
Drug Dependency			____________	____________
Headaches			____________	____________
Asthma			____________	____________
Other			____________	____________

Menstrual History

Age began menstruating: ______years of age   Has never menstruated

Date of last menstrual cycle: _________________   Weight at that time: __________pounds

Dieting History

Has your child ever dieted?   Yes   No   How many diets has your child been on? ___

Age of first diet: ______years   Weight at that time: __________pounds

Why did your child go on the diet? ______________________________

____

Exercise History

Does your child currently exercise/participate in sports: Yes   No

Type, duration, frequency, and intensity of exercise activities: ______________________________

____

____

What types of physical activities does your child enjoy? ______________________________

____

Family Weight History

Are any members of your family overweight? Yes No

Explain: ____

Are any members of your family underweight? Yes No

Explain: ____

Does anyone in your family diet? Yes No

Explain: ____

Did/Does anyone in your family have an eating disorder? Yes No

Explain: ____

Does your family eat meals together? Yes No

What meals? ____

Eating Habits

Does your child regularly skip meals? Yes No

How many days per week does your child eat: Breakfast:______Lunch:______Dinner:____Snacks:_______

When does your child usually snack? ____

Does your child eat out (restaurants, take-out, fast food, etc.)? Yes No

How often? ____

List restaurants usually chosen: ____

Example of food choices: ____

Does your child eat snacks at school? Yes No

What are your child's favorite foods? ____

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What food does your child dislike? ____

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Please list your main concerns about your child's nutritional intake: ______________________

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