Health by Design Natural Clinic

Pediatric Nutrition Questionnaire

Child's Name (First/Last): _____ Date: _____

Parents/ Care Givers Name (s)_____

Home Phone: _____Cell Phone: _____ Work Phone: _____

Address: _____ City/State/Zip: _____

Email Address: _____

Age: _____ DOB: _____ Height: _____ Weight: _____ Gender: _____

Primary Care Provider: _____

Address/ Phone_____

Grade in School: _____ Name of School: _____

Office Use Only
Time: _____ Appt: _____
Referral Source: _____
BP: _____ Temp: _____

Parent's marital status: □Single □Married □Divorced □Separated □Widowed □Partnership

Parent's occupation(s):_____

Siblings:_____Brother(s) _____Sister(s)

What are your most important health concerns or goals? List in order of importance:

1. _____
2. _____
3. _____

Please describe any important events which may have contributed to any of the above problems: _____

_____

_____

If you have seen other practitioners for these problems, please note when, for how long, and the results of these evaluations or treatments: _____

_____

_____

Medical History:

Birth weight: _____ Breast-fed? _____ How long? _____ Age foods were first introduced? _____

List complications: _____

Was mother under stress during prior to or during pregnancy? □ Yes □ No

Did mother have any postpartum depression or diabetes after pregnancy? □ Yes □ No

Did your child have: □ Lactose intolerance □ Colic

Food allergies/intolerances as an infant/toddler: □ Yes □ No

Symptoms: _____

Normal growth and development? □ Yes □ No

List complications: _____

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

List any medications your child is taking or has taken in the last year: _____

_____

List any nutritional/herbal supplements your child is taking or has taken in the past year: _____

_____

Has your child ever had surgery? □ Yes □ No

What type of surgery? _____ When? _____

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

Disease/Condition	**Child**	**Family**	**Relationship**	**Treatment**
Diabetes	□	□		
Kidney Disease	□	□		
Cardiovascular Disease	□	□		
Heart Attack	□	□		
Hypertension	□	□		
High Cholesterol	□	□		
Cancer	□	□		
Obesity	□	□		
Intestinal problems	□	□		
Menstrual problems	□	□		
Osteoporosis	□	□		
Food Allergies	□	□		
Food Intolerances	□	□		
Mental Health Issues	□	□		
Drug Dependency	□	□		
Asthma	□	□		
Headaches	□	□		
Other: _____	□	□		

Menstrual History:

Age began menstruating: _____ ☐ Has never menstruated

Date of last menstrual cycle: _____

Problems with cycle? ☐ Irregular ☐ Heavy flow ☐Cramps ☐PMS ☐Irritability ☐Mood Swings

General Symptoms:

Does your child…..

Have frequent aches or pains □ Yes □ No If yes, where? _____

Bruise Easily □ Yes □ No

Puffy eyes □ Yes □ No

Dark circles around eyes □ Yes □ No

Brittle Nails □ Yes □ No

Hair Loss □ Yes □ No

Brittle Hair □ Yes □ No

Do you get colds/flu frequently □ Yes □ No

Memory Loss □ Yes □ No ……Long Term / Short Term

Acne, itchy or blotchy skin □ Yes □ No

Do you frequently feel □ Hot □ Cold □ Fatigued

Sleep:

What time does your child usually go to sleep _____ Arise_____ Does he/she have problems getting to sleep? □ Yes □ No

How many times does your child wake during the night _____ What times? _____

Does he/she fall right back to sleep or lie awake for a while? _____

When your child first wakes up is he/she □Rested □Tired

Does your child have □ dreams □ nightmares Are they vivid? □ Yes □ No

Eating Habits and Digestion:

Does your child regularly skip meals? □ Yes □ No

How many meals days per week does your child eat: Breakfast: _____ Lunch: _____ Dinner: _____ Snacks: _____

What does your child usually have for a snack? _____

Does your child eat out (restaurants, take-out, fast food, etc.?)

How often? _____ Restaurants usually chosen: _____

Does your child take lunch to school or buy lunch at school? _____

Example of food choices: _____

What does your child not eat or dislike? _____What foods do they like most? _____

Describe your child's diet: _____

Check any of the following problems which your child experiences:

□Stomach Ache □Bloating □Nausea □Heartburn □Vomiting

□Gas □Rectal Itching or Burning □Blood in Stool □Diarrhea □Incontinence

□Constipation (less than 1 bowel movement per day or sluggishness)

Does your child experience discomfort or fatigue after eating any of the following? (Check all that apply):

□Milk □Soy Products □Corn □Eggs □Wheat

□Sugar □Pepper □Spices □Other: _____

Check any cravings your child may occasionally have:

□Sweets □Chocolate □Salty Foods □Soda □Fried Foods

Do you use artificial sweeteners? (Check all that apply)

□NutraSweet □Splenda □Equal □Xylitol □Stevia □Other: _____

Informed Consent

Our services, products and the claims made have not been evaluated by the FDA, and are not intended to diagnose, treat, cure or prevent any disease.

So that we may accommodate all clients during their scheduled appointment times, we kindly request a 24 hour notice for re-scheduling appointments. We must impose a $50 cancellation fee if 24 hour notice is not given.

I have read and understand the above information.

Clients Signature:_____ Date:_____

FOR OFFICE USE ONLY:

_____

_____

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