

ADOLESCENT NUTRITION QUESTIONNAIRE

Name: _____ Age: _____ Date of Birth: _____

Medical History

Please check if you or a family member has a history of any of the following conditions:

| Condition | Family | Self | Condition | Family | Self |
|---------------------------------|--------|------|--------------------------|--------|------|
| Anemia | | | Kidney Disease | | |
| Blood Clots/Clotting Difficulty | | | Obesity | | |
| Cancer | | | Osteoporosis | | |
| Diabetes | | | Ulcer Disease | | |
| Eating Disorder | | | Urinary Tract Infections | | |
| High Blood Pressure | | | Hyperparathyroidism | | |
| High Cholesterol | | | Other: | | |

Please list all medications/vitamins/minerals/supplements the patient is currently taking:

| Name | Dosage | Frequency | Prescribed by (as appropriate): |
|------|--------|-----------|---------------------------------|
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Current Weight: _____ Pounds

Current Height: _____ Feet/inches

Please have the patient complete:

Nutrition History

How would you rate your appetite? ___ Good ___ Fair ___ Poor

Which of these meals or snacks do you usually eat (check all that apply)?

- | | |
|---------------------|-----------------------|
| _____ Breakfast | _____ Afternoon snack |
| _____ Morning snack | _____ Dinner/supper |
| _____ Lunch | _____ Evening snack |

Do you skip breakfast/lunch/dinner three or more times a week?

_____ YES

_____ NO

Do you eat dinner/supper with your family four or more times a week?

_____ YES

_____ NO

Do you fix or buy the food for any of your family meals?

_____ YES

_____ NO

Do you eat or take out a meal from a fast-food restaurant two or more times a week?

_____ YES

_____ NO

Do you follow a special diet? If so what kind of a diet and who told you to follow it?

Are you concerned about your weight?

_____ YES

_____ NO

Are you on a diet right now to lose weight or maintain your weight?

_____ YES

_____ NO

Please list any known food allergies and foods you avoid:

Are you a vegetarian?

_____ YES

_____ NO

Which of these foods did you eat last week (check all that apply)?

_____ Bread

_____ Cereal/grits

_____ Rolls

_____ Popcorn

_____ Bagels

_____ Noodles/pasta/rice

_____ Crackers

_____ Tortillas

_____ Other grains: _____

Which of the following did you drink last week (check all that apply):

_____ Regular soft drink

_____ Flavored milk

_____ Diet soft drink

_____ Coffee/tea

_____ Fruit-flavored drinks

_____ Tap/bottled water

_____ Whole milk

_____ Juice

_____ 2% milk

_____ Sports drinks

_____ 1% milk

_____ Skim milk

Which of these foods did you eat last week (check all that apply)?

| | |
|--|--|
| <input type="checkbox"/> Corn | <input type="checkbox"/> Greens (collard, spinach) |
| <input type="checkbox"/> Peas | <input type="checkbox"/> Green salad |
| <input type="checkbox"/> Potatoes | <input type="checkbox"/> Broccoli |
| <input type="checkbox"/> French fries | <input type="checkbox"/> Carrots |
| <input type="checkbox"/> Other vegetables: _____ | |

Which of these foods did you eat/drink last week (check all that apply)?

| | |
|---|----------------------------------|
| <input type="checkbox"/> Apple/juice | <input type="checkbox"/> Bananas |
| <input type="checkbox"/> Oranges/juice | <input type="checkbox"/> Peaches |
| <input type="checkbox"/> Grapefruit/juice | <input type="checkbox"/> Pears |
| <input type="checkbox"/> Grapes/juice | <input type="checkbox"/> Berries |
| <input type="checkbox"/> Other fruit/juice: _____ | |

Which of these foods did you eat/drink last week (check all that apply)?

| | |
|--|--|
| <input type="checkbox"/> Whole milk | <input type="checkbox"/> Yogurt |
| <input type="checkbox"/> 2% milk | <input type="checkbox"/> Cheese |
| <input type="checkbox"/> 1% milk | <input type="checkbox"/> Ice cream |
| <input type="checkbox"/> Skim milk | <input type="checkbox"/> Flavored milk |
| <input type="checkbox"/> Other milk and dairy: _____ | |

Which of these foods did you eat last week (check all that apply)?

| | |
|--|---|
| <input type="checkbox"/> Beef/hamburger | <input type="checkbox"/> Fish |
| <input type="checkbox"/> Pork | <input type="checkbox"/> Cold Cuts |
| <input type="checkbox"/> Chicken | <input type="checkbox"/> Sausage/bacon |
| <input type="checkbox"/> Turkey | <input type="checkbox"/> Peanut butter/nuts |
| <input type="checkbox"/> Tofu | <input type="checkbox"/> Dried Beans |
| <input type="checkbox"/> Other meat and meat alternatives: _____ | |

Which of these foods did you eat last week (check all that apply)?

| | |
|---|------------------------------------|
| <input type="checkbox"/> Cake/cupcake | <input type="checkbox"/> Chips |
| <input type="checkbox"/> Pie | <input type="checkbox"/> Doughnuts |
| <input type="checkbox"/> Cookies | <input type="checkbox"/> Candy |
| <input type="checkbox"/> Other fats and sweets: _____ | |

Physical Activity History

Did you participate in physical activity the past week – like riding your bike, walking?

YES NO

Do you spend more than 2 hours a day watching tv, playing video games, on the computer?

YES NO

Do you have PE (Physical Education) in school? Yes No

If yes, for how long and how many times a week? _____

List the sports you play and what seasons you play them:

Do you play outside after school? _____ Yes _____ No

Do you have a TV in your room? _____ Yes _____ No

To the parent:

Is there any other additional information that you believe is important for us to know?

I certify that all the information I have provided above is accurate and complete to the best of my knowledge as of the date of my signature below. I agree to accept responsibility for omissions regarding my failure to disclose any past or currently health/medical conditions. In addition, I acknowledge receiving Nutrition Specialists, LLC and Budding Baby's HIPPA Privacy Notice.

Signature: _____

Date: _____

Print Name: _____

Please complete this 3-day food diary depicting all food and beverage intake, providing as much detail as possible.

Food Diary Day 1

| Time of Day | Meal Eaten | Food Eaten (please be specific including amounts, types of food, etc.) |
|---------------|------------|---|
| Sample Record | | |
| 8:30 am | Breakfast | 1 ½ cup Chocolate Chex with ½ cup 2% milk |
| | | 1 cup regular coffee with 2 Tbsp half and half and 1 Tbsp sugar |
| | | 1 homemade cinnamon bun (about size of my fist) |
| | | 2 slices bacon |
| | Breakfast | |
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| | Lunch | |
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Food Diary Day 2

| Time of Day | Meal Eaten | Food Eaten (please be specific including amounts, types of food, etc.) |
|-------------|---------------|---|
| | Sample Record | |
| 8:30 am | Breakfast | 1 ½ cup Chocolate Chex with ½ cup 2% milk |
| | | 1 cup regular coffee with 2 Tbsp half and half and 1 Tbsp sugar |
| | | 1 homemade cinnamon bun (about size of my fist) |
| | | 2 slices bacon |
| | Breakfast | |
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Food Diary Day 3

| Time of Day | Meal Eaten | Food Eaten (please be specific including amounts, types of food, etc.) |
|---------------|------------|---|
| Sample Record | | |
| 8:30 am | Breakfast | 1 ½ cup Chocolate Chex with ½ cup 2% milk |
| | | 1 cup regular coffee with 2 Tbsp half and half and 1 Tbsp sugar |
| | | 1 homemade cinnamon bun (about size of my fist) |
| | | 2 slices bacon |
| | Breakfast | |
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