

CHILDHOOD 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):

Current Weight: _____ Pounds

Current Height: _____ Feet/inches

Nutrition History

How would you rate your child's appetite? ___ Good ___ Fair ___ Poor

Which of these meals or snacks did your child eat yesterday (check all that apply)?

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

Does your child skip breakfast/lunch/dinner three or more times a week?

_____ YES

_____ NO

Does your child eat dinner/supper with your family four or more times a week?

_____ YES

_____ NO

Does your child eat or take out a meal from a fast-food restaurant two or more times a week?

_____ YES

_____ NO

Is your child a vegetarian?

_____ YES

_____ NO

Does your child follow a special diet? If so what kind and who told you to follow it?

Please list any known food allergies and foods you avoid:

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

_____ Bread

_____ Rolls

_____ Bagels

_____ Crackers

_____ Other grains: _____

_____ Cereal/grits

_____ Popcorn

_____ Noodles/pasta/rice

_____ Tortillas

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

_____ Regular soft drink

_____ Diet soft drink

_____ Fruit-flavored drinks

_____ Whole milk

_____ 2% milk

_____ 1% milk

_____ Flavored milk

_____ Coffee/tea

_____ Tap/bottled water

_____ Juice

_____ Sports drinks

_____ Skim milk

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

_____ Corn

_____ Peas

_____ Potatoes

_____ French fries

_____ Other vegetables: _____

_____ Greens (collard, spinach)

_____ Green salad

_____ Broccoli

_____ Carrots

Which of these foods did your child 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
Other fruit/juice: _____	

Which of these foods did your child 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
Other milk and dairy: _____	

Which of these foods did your child 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
Other meat and meat alternatives: _____	

Which of these foods did your child 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
Other fats and sweets: _____	

Are you concerned about your child's weight?

YES NO

Is your child on a diet right now to lose weight or maintain their weight?

YES NO

Physical Activity History

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

YES NO

Does your child spend more than 2 hours a day watching tv, playing video games, on the computer?

YES NO

Does your child PE (Physical Education) in school? Yes No

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

List the sports your child plays and what seasons you play them:

Does your child play outside after school? _____ Yes _____ No

Does your child have a TV in their room? _____ Yes _____ No

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 existing 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	
	Lunch	
	Dinner	
	Snack	
	Snack	
	Snack	
	Other	

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	
	Lunch	
	Dinner	
	Snack	
	Snack	
	Snack	
	Other	

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	
	Lunch	
	Dinner	
	Snack	
	Snack	
	Snack	
	Other	