

Pediatric Nutrition Assessment Form

Name of Child _____ Birth Date _____ Age _____
Name of Parents _____
Address _____
Telephone numbers _____ E-mail _____
Pediatrician _____
Health Insurance _____
Referred by _____
Today's Date _____

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

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

Describe your child's physical activity

How much time does your child spend outside per day?
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?

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

Height _____ Current weight _____

List all medications, vitamin, mineral, and herbal supplements that he/she is taking:

_____	_____	_____
_____	_____	_____
_____	_____	_____

Describe your child's health history and approximate date of diagnosis:

_____	_____
_____	_____
_____	_____

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

How would you describe your child's appetite?

Are there any foods or textures that your child dislikes?

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

Please request your child's growth chart to be faxed to my office at 603-766-1966