

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? _____

