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Certified Nutritionist, Registered Dietitian

Child's Name________________________________Sex: M F Age______ Birthdate___________
Parent's Name__________________________ Home Phone _____________ Work Phone _______
Address_____________________________________ Preferred email __________________________
Name of your child's doctor and address____
Why do you want a consultation with the nutritionist? ______________________________________
What is the best way to contact you to schedule an appointment? ____________________________
The information provided below is completely confidential. This information will not be released without written permission.

APPETITE

How would you describe your child's appetite? ( ) Hearty ( ) Moderate ( ) Poor

Does your child have difficulty chewing, swallowing or digesting food? ( ) Yes ( ) No
Please explain____

Does your child have frequent problems with any of the following? ( ) Constipation ( ) Diarrhea
( ) Vomiting ( ) Frequent illness Please explain____

Does your child have any medical or dental problems (e.g. diabetes, heart problems, disabilities)?
( ) Yes ( ) No Please explain____

EATING PATTERN AND ATTITUDES ABOUT FOOD

Does your child eat at approximately the same time every day? ( ) Yes ( ) No ( ) Sometimes
If yes or sometimes, which meals and how frequently? ___________________________________

How many **meals** does your child have each day? ___________________________________

How many **snacks** does your child have each day? _________________________________

During one week, where does your child eat most of his/her food? Home____ School____
Babysitter or daycare______ Restaurant_____ Other__________________ (identify)

FOOD CHOICES

Is there any food your child **cannot** eat or drink? ( ) Yes ( ) No If yes, what food(s)? _________
What happens when your child eats/drinks this food? ____

Is your child allergic to any foods? ( ) Yes ( ) No If yes, what foods? ________________
What happens when your child eats this food? ____

Is your child on a special diet? (example - diabetic, vegetarian) ( ) Yes ( ) No
Specify type of diet__________________________________Who recommended it? ______________
Has your child been on special diets in the past? ______________What kind? ___________________

How many servings of fruits does your child eat/drink each day? _____ Vegetables _____
Please list kinds of fruits and vegetables eaten. _____________________________________

How much of the following drinks does your child have each day? Milk _____What kind? ______
Kool-Aid_____ Juice______ Soda_______ Sport drinks______ Tea/coffee____ Other_______

(over)

Please describe what your child **usually** eats for breakfast, lunch, dinner and snacks.

	Meal	Food/Method of Preparation	Amount Eaten
______	Breakfast	______________________________	_______________
______	Snack	______________________________	_______________
______	Lunch	______________________________	_______________
		______________________________	_______________
______	Snack	______________________________	_______________
______	Dinner	______________________________	_______________
		______________________________	_______________
______	Snack	______________________________	_______________

WEIGHT INFORMATION

What is your child's current weight? ___________ Height? ___________ How do you feel about your child's weight right now? ( ) Too heavy ( ) Too thin ( ) OK

What is your child's growth pattern in the past year? Please describe_________________________

Has your child used any weight loss programs in the past? ( ) Yes ( ) No
If yes, please describe ____

Does your child vomit or have diarrhea to keep her/his weight down? ( ) Yes ( ) No
( ) Every day ( ) 3-4 times/week ( ) Never ( ) Sometimes

SUPPLEMENTS/ MEDICATIONS AND HEALTH INFORMATION

Is your child taking any vitamin, mineral or herbal supplements? ( ) Yes ( ) No
If yes, what and how often (please provide brand if you know) _____________________________
____

Does your child regularly take any "over the counter" **medications** or those prescribed by your doctor? ( ) Yes ( ) No If yes, what medications? _________________________________

EXERCISE & OTHER INFORMATION

What does your child do for exercise? ____

Indicate the person who does the following in your household? Plans/ the meals_______________
Buys the food_________________________ Prepares the food______________________

Do you usually eat with the TV on? ( ) Yes ( ) No

Do you have any questions or concerns about the following? ( ) Picky eaters ( ) Healthy snacks
( ) Recipe ideas/menu planning ( ) Exercise ideas ( ) Other concerns___________________

I hereby authorize Marianne Romano to release this patient's nutritional care record for the purpose of communicating nutritional care plans with other pertinent medical care providers.

_______________________________________ _____________

Signature **Date**

Relationship to patient_______________________

(3.06)