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Nutrition Works, Inc.

NUTRITIONAL QUESTIONAIRE FOR CHILDREN

To enhance your scheduled consult time, please have this back to us at least 1 day prior to your appointment, if possible. You can scan and email it to me: Traci@hudsonvalleynutritionworks.com. If you have any questions, please call me at 914-474-3795.

Child's name:_____ Age:_____ Birth date:_____

Gender: _____ Height or Length:_____ Weight: _____

Place of Birth: _____

Mother's Name (or Guardian):_____

Address:_____ City:_____ State:_____ Zip:_____

E-mail Address: _____ Fax Number : (_____) _____- _____

Home Phone: (____) _____- _____ Work: (____) _____- _____ Cell: (____) _____-_____

Age: _____ Occupation: _____

Statement of Heath: _____

Father's Name (or Guardian): _____

Address:_____ City:_____ State:_____ Zip:_____

E-mail Address: _____ Fax Number : (_____) _____- _____

Home Phone: (____) _____- _____ Work: (____) _____- _____ Cell: (____) _____-_____

Age: _____ Occupation: _____

Statement of Health: _____

Please rank child's current problems by priority and fill in the other boxes as completely as possible:

DESCRIBE PROBLEM	MILD/MODERATE/SEVERE	TREATMENT APPROACH	SUCCESS
Example: Post Nasal Drip	Moderate	Elimination Diet	Moderate

Please check any other problems:

□ Speech	□ Immaturity	□ Learning disability
□ Behavior	□ Sweet tooth	□ Often tired
□ Short attention span	□ Craves junk food	□ Excessive fluid intake
□ Academic problems	□ Fear, Anxiety	□ Poor coordination
□ Bed wetting	□ Allergies	□ Hyperactivity

PRECONCEPTION INFORMATION:

Were there any serious illnesses prior to pregnancy? □ Yes □ No

Any allergies or gastrointestinal issues? □ Yes □ No

PRENATAL INFORMATION:

Please explain anything unusual about the birth: _____

_____

_____

_____

_____

POST NATAL DEVELOPMENT:

Did baby have early feeding problems? □ Yes □ No

If yes, please describe: _____

_____

Did child hit developmental milestones at appropriate times? (i.e. speech)? □ Yes □ No

If no, please explain: _____

_____

Was baby colicky? □ Yes □ No

If yes, please explain: _____

_____

PERINATAL INFORMATION:

Where was child born? (hospital, home, etc.) _____

Birth Weight: _____ Was baby born pre-mature? □ Yes □ No

Length of labor: _____ Was labor difficult? □ Yes □ No

Was baby born naturally or by cesarean section? _____

Were there any known or observable issues or abnormalities of baby at birth? □ Yes □ No

If yes, please describe: _____

_____

Did baby need treatments immediately after birth? (i.e. tube feedings, surgery) □ Yes □ No

If yes, please describe: _____

Did baby have sucking problems at birth or since? □ Yes □ No

If yes, please explain: _____

_____

POST NATAL INFORMATION:

Did baby have early feeding problems? □ Yes □ No

If yes, please explain: _____

_____

At what age was child toilet trained? _____Was difficulty encountered? □ Yes □ No

If yes, please explain: _____

_____

MEDICAL HISTORY:

Has child had any of the following diseases? Check all that apply.

_____ Chicken Pox	_____ Measles (Red)	_____ Measles (German)
_____ Roseola	_____ Mumps	_____ Whooping cough
_____ Influenza (flu)	_____ Mononucleosis	_____ Scarlet fever
_____ Rheumatic fever	_____ Hepatitis	_____ Pneumonia
_____ Tuberculosis	_____ Encephalitis	_____ Epilepsy
_____ Nervousness	_____ Nervous breakdown	_____ Emotional problems
_____ Fainting spells	_____ Heart palpitations	_____ Shortness of breath
_____ Other		

Please describe any unusual complications of those listed above: _____

_____

_____

_____

_____

Has child ever had a high temperature? □ Yes □ No

If yes, how high? _____ Please explain: _____

_____

Has child ever had injuries? □ Yes □ No

If yes, state location and results: _____

_____

Has child ever had any operations? □ Yes □ No

If yes, state type and results: _____

_____

Please list family disease history (i.e. cancer, diabetes, heart disease, epilepsy, etc)

Mother's side: _____

_____

_____

Father's side: _____

_____

_____

Please list any *current* medical issues:

_____

_____

_____

Has the child experienced any major stress or life change recently? Please explain: _____

_____

_____

STOMACH & INTESTINAL:

Does child have any *current s*tomach or Intestinal disorders? □ Yes □ No

If yes, please explain: _____

_____

Please check the appropriate box below with information about child's recent bowel movements:

Frequency:

□ More than 3 times per day □ 2-3 times per day □ 1 time per day □ 4-6 times per week

□ 2-3 times per week □ 2-3 times per week □ 1 time or less per week

Consistency:

□ Soft and well formed □ Often float □ Difficult to pass □ Diarrhea

□ Thin, long or narrow □ Small and hard □ Loose, but not watery

□ Alternating between hard and loose/watery

Color:

□ Dark brown □ Medium brown □ Very dark brown □ Very dark or black

□ Greenish □ Blood is visible □ Varies a lot □ Yellow, light brown

□ Greasy, shiny appearance

Does child experience anal itching? □ Yes □ No

SKIN & SKELETON:

Does child have any *current s*kin disorders? (i.e. eczema, excessive dryness, burns)

□ Yes □ No

Bone or joint disorders? (ie. arthritis) □ Yes □ No

ENDOCRINE:

Does child have any *current:*

Issues being over or underweight: □ Yes □ No

Diabetes? □ Yes □ No

If yes, please explain and provide age of diagnosis: _____

_____

High or low blood sugar? □ Yes □ No

Thyroid imbalance? □ Yes □ No

Menstrual disorder? □ Yes □ No □ N/A

HEART AND LUNGS:

Does child have a *current:*

Chronic cough? Q □ Yes □ No

Bronchial disorder? □ Yes □ No

Heart disorder? □ Yes □ No

Heart murmur? □ Yes □ No

Lung disorder? □ Yes □ No

CENTRAL NERVOUS SYSTEM:

Does child have any *current:*

Reoccurring headaches or dizziness? □ Yes □ No

Coordination problems? □ Yes □ No

Head or brain injury? □ Yes □ No

Nerve or muscle disorders? □ Yes □ No

Seizure disorders? □ Yes □ No

SPEECH AND AUDITORY:

Does child have speech problems now? □ Yes □ No

Does child have difficulty with hearing? □ Yes □ No

Is child in speech therapy? □ Yes □ No

EARS, NOSE, AND THROAT:

Does child have any *current:*

Ear disorders? □ Yes □ No

Nose disorders? □ Yes □ No

Throat disorders? □ Yes □ No

DENTAL HISTORY

Has child had any cavities in the last 2 years? □ Yes □ No

Do child's gums ever bleed? □ Yes □ No

ALLERGY & TOXIC POTENTIAL:

Does child have any:

Food allergies or intolerances? □ Yes □ No

Drug/medication allergies? □ Yes □ No

Environmental allergies? □ Yes □ No

Do odors such as perfumes, cleaning solutions, smoke, etc affect child? □ Yes □ No

BEHAVIOR AND EMOTIONAL CHARACTERISTICS

Does your child exhibit any anxiety? □ Yes □ No

Does child seek company of older children? □ Yes □ No

Does child annoy or antagonize other children? □ Yes □ No

Does child bite nails? □ Yes □ No

Is child unusually active? □ Yes □ No

Is child unusually distractible? □ Yes □ No

Is child unusually tired? □ Yes □ No

Is child unusually destructive? □ Yes □ No

Does child have poor social adjustment to family, classmates, and/or teachers? □ Yes □ No

Is child's behavior changeable? One hour pleasant and the next disagreeable? □ Yes □ No

Has a change of surroundings ever made a distinct change in behavior? □ Yes □ No

LIFESTYLE INFORMATION:

Does child need more sleep than most? □ Yes □ No

Does child have trouble getting to sleep? □ Yes □ No

What is child's usual bed time? _____ Wake time? _____

Check off typical bedtime activities:

□ Watch televison □ Read a book □ Listen to music □ Bed time snack □ Bathe/shower

□ Other (please specify): _____

Does child exercise regularly? □ Yes □ No

If yes, please specify how many times per week: □ Once □ 2 times □ 3 times □ 4 or more times

Time length per session: □ < 15 minutes □ 15-30 minutes □ 30-45 minutes □ > 45 minutes

What type of activities is child involved in (i.e. dance, soccer, gymnastics, tennis, etc)? _____

_____

_____

_____

MEDICATIONS & SUPPLEMENTS

Please list any medications child is taking on a *daily/regular* basis:

Medication Name	Purpose	Dosage	Start Date

Please list all vitamins, minerals, and other nutritional supplements child is taking on a *daily/regular* basis. Indicate dosage (mg or IU), and form (i.e. calcium carbonate vs. calcium lactate).

******PLEASE BRING BOTTLES TO APPOINTMENT******

Vitamin/Mineral/Supplement	Brand Name	Dosage	Start Date

Does child take over the counter medications on an *occasional* basis (i.e. Tylenol, cold medicine, etc)?

□ Yes □ No If yes, which ones and how often? _____

_____

Has child ever been on antibiotics for a prolonged period of time? □ Yes □ No

If yes, please explain:_____

_____

Has child taken oral steroids (i.e Prendisone)? □ Yes □ No

DIETARY HABITS:

Is the child currently on a special diet (i.e.- vegetarian, gluten-free, etc.)? □ Yes □ No

Does child avoid certain foods? □ Yes □ No

If yes, which foods and why? _____

Does child crave certain foods? □ Yes □ No

If yes, which foods? _____

Does child enjoy eating? □ Yes □ No

Comments: _____

_____

Does child currently or typically have symptoms (belching, fatigue, bloating, etc) immediately after eating?

□ Yes □ No

If yes, please explain: _____

_____

Are these associated with any particular foods (i.e. milk: causes gas, diarrhea): _____

_____

_____

Does child have delayed symptoms after eating certain foods? (Delayed symptoms may not be evident for 24 hours or more after eating) □ Yes □ No

If yes, please explain: _____

_____

Does skipping meals affect symptoms? □ Yes □ No

If yes, please explain: _____

_____

What is child's usual:

Breakfast time: _____ Lunch time: _____ Dinner time: _____ Snacks: _____

Please comment on child's typical eating habits: _____

_____

_____

_____

_____

Place a mark after the food/drink that applies to a typical day of child's current diet:

Breakfast		Lunch		Dinner	
None		None		None	
Cereal		Eat in cafeteria		Pasta	
Wheat bran		Eat in restaurant		Potato	
Oatmeal		Leftovers		Brown rice	
Toast		Meat sandwich		White rice	
Bagel		Fish sandwich		Beans (legumes)	
Sweet roll		Lettuce (on sandwich)		Fish	
Donut		Tomato		Red meat	
Eggs		Salad		Poultry	
Bacon/sausage		Salad dressing		Salad	
Fruit		Soup		Salad dressing	
Yogurt		Fruit		Green vegetables	
Milk		Yogurt		Carrots	
Juice		Milk		Yellow vegetables	
Water		Juice		Milk	
Butter		Water		Juice	
Margarine		Regular soda		Water	
Sugar		Diet soda		Regular soda	
Sweetener		Butter		Diet soda	
Leftovers		Margarine		Butter	
Other:		Mayonnaise		Margarine	
Other:		Sugar		Sugar	
Other:		Sweetener		Sweetener	
Other:		Other:		Other:	
		Other:		Other:	
		Other:		Other:	
		Other:		Other:	

COMMENT SECTION:

Please list anything else you think I should know: _____

_____

_____

_____

_____

_____

_____