

## Pediatric Nutrition Questionnaire

(For infants through 12 Y.O.)

Date:

Phone number:

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Initial \_\_\_\_\_

Gender: (circle) Male / Female

Date of Birth: \_\_\_\_\_

Ht/Length: \_\_\_\_\_ (in.) Current Wt: \_\_\_\_\_ (lbs.) Usual Wt: \_\_\_\_\_ (lbs.)

Date this weight was last held: \_\_\_\_\_

Please record a typical day's intake of foods and beverages. Be as specific as possible with portions (i.e. ½ cup, 1 cup), food description (i.e. non-fat, low fat, whole), condiments (with mayo), and cooking method (i.e. grilled, baked, fried)

Breakfast

Mid Morning Snack

Lunch

Afternoon Snack

Dinner

Bed Time Snack

How would you describe your child's appetite? \_\_\_good \_\_\_fair \_\_\_picky

Please list any food allergies or intolerance: \_\_\_\_\_

List any medications and dosage: \_\_\_\_\_

List any vitamins, minerals, herbs or supplements: \_\_\_\_\_

Fast Food. How often does your child eat fast food meals such as hamburgers, tacos, fried chicken, hot dogs, French fries, sweetened beverages such as lemonade, colas, fruit flavored soft drinks?

\_\_\_ four or more times/week      \_\_\_ two to three times/week  
\_\_\_ two to four times/month      \_\_\_ seldom or never

Continued on next page.

If your child is 4 years old or younger, does he or she eat any of these foods? Check all that apply

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Nuts, seeds, peanuts | <input type="checkbox"/> Raisans        | <input type="checkbox"/> Hot dogs or sausage links         |
| <input type="checkbox"/> Peanut Butter        | <input type="checkbox"/> Raw apples     | <input type="checkbox"/> Hard candy, Gumdrops, Jelly beans |
| <input type="checkbox"/> Popcorn              | <input type="checkbox"/> Raw vegetables | <input type="checkbox"/> Whole grapes                      |

Does your child take a bottle to bed at night? \_\_\_\_\_

How would you rate your child's recent energy level? (circle)      **Increased/ No change/ Decreased**

Describe your child's usual active level and amount of time spent for the activity (i.e. ballet, swimming, soccer, foot ball, baseball, fitness videos aor computer fitness activities, etc) \_\_\_\_\_

\_\_\_\_\_

Describe the activity and amount of time spent in sedentary activities ( watching TV, computer time, sedentary video and computer games) \_\_\_\_\_

\_\_\_\_\_

What are your main nutrition concerns you would like addressed today?: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Where they any days within the last month when your family didn't have enough food to eat or money to buy food?     Yes       No

How would you rate your child's readiness (receptiveness) to begin making dietary changes? (circle):

**Very Ready / Somewhat Ready / Not Ready**