Pediatric Nutrition Intake Form
(For children up to the age of 12 years)

Name of child: __________________________

Date of birth: ______________ Sex: F / M  Height: _______  Weight: _______

Address: __________________________________________________________

City: ________________ Province: ________________  Postal Code: __________

Parent/Guardian Phone: _____________________________________________

Parent/Guardian Email: _____________________________________________

Who can we thank for this referral (Google, Website, Name, Other): _________________

Please answer each of the following questions to the best of your ability:

What are your child’s main health concerns or reasons for coming? Please list in priority:

____________________________________________________________________

____________________________________________________________________

Has your child ever been diagnosed with health condition related to their main health concern(s)?
If yes, please describe: ___________________________________________________

Has there been any significant physical or emotional trauma or loss in the last 5 years? ______

____________________________________________________________________

Does your child live with you: Full time? _____  Part time? _____

Is your child adopted? Yes/No

What level of stress is your child experiencing at this time?:

Minimal _____Average _____ Considerable _____ Unbearable _____

What are the major causes or factors involved in his or her stress? (Check all that apply)

Family _____ Friends _____ School _____ Health _____ Other ______

For office use only:
How does your child’s stress manifest itself? (E.g.: anxiety, nightmares, overreactions, difficulty leaving you, new unhealthy habits)

How does your child cope with stress?

What does your child do for exercise? (Include frequency)

What does your child do for extra-curricular activities? (Include frequency)

Does he or she enjoy these activities?

What are your child’s interests or hobbies (other than extra-curricular activities)?

How many hours on average does your child sleep daily? (Include naps)

What time does your child go to sleep at night? What time does your child awaken in the morning?

Does your child awaken feeling rested?

Does your child sleep through the night?

How many hours does your child spend on average:

In the car
Watching television
Reading
In front of computer

Does your child actively participate in any spiritual discipline (church, religious group, meditation, etc.)?

Is your child regularly in the care of someone other than your spouse i.e. daycare?

Does anyone in your household smoke? Yes/No

MEDICAL HISTORY:

Does your child have any allergies or sensitivities? If so, please list:

Does your child have any silver mercury fillings? Yes/No

Does your child have a history of prenatal drug/alcohol exposure? Yes/No

Has your child ever been diagnosed with an illness? Specify:
Hospitalized? Reason: ____________________________________________

How often does your child have a bowel movement? _______________________

Does he or she strain to have a bowel movement? Yes/No/Occasionally

- Related to a particular food or circumstance? _______________________

Does he or she have loose bowel movements? Yes/No/Occasionally

- Related to a particular food or circumstance? _______________________

Please circle all that apply to your child:

<table>
<thead>
<tr>
<th>ADD/ADHD</th>
<th>Ear infections</th>
<th>Thrush</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dental problems</td>
<td>Rheumatic Fever</td>
<td>Chicken Pox</td>
</tr>
<tr>
<td>Neural Tube Defect</td>
<td>Autism</td>
<td>Measles</td>
</tr>
<tr>
<td>Allergies (environmental)</td>
<td>Frequent colds</td>
<td>Whooping cough</td>
</tr>
<tr>
<td>Developmental problems</td>
<td>Scarlet Fever</td>
<td>Colic</td>
</tr>
<tr>
<td>Pneumonia</td>
<td>Blue Baby</td>
<td>Meningitis</td>
</tr>
<tr>
<td>Allergies (food)</td>
<td>Impaired speech</td>
<td>Croup</td>
</tr>
<tr>
<td>Diarrhea</td>
<td>Tonsillitis</td>
<td>Mumps</td>
</tr>
<tr>
<td>Rubella</td>
<td>Bronchitis</td>
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<tr>
<td>Asthma</td>
<td>Jaundice</td>
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</tbody>
</table>

If any of the following apply to your child, please mark C for current and P for past symptoms:

| __Abdominal pain | __Heart murmur | __Talks in sleep |
| __Excessive fatigue | __Rash | __Cough |
| __Night sweats | __Body odour | __Jaundice |
| __Acid reflux | __High fevers | __Walks in sleep |
| __Excessive perspiration | __Sensitive to light | __Cries easily |
| __No appetite | __Bruises easily | __Joint pains |
| __Anemia | __Hives | __Weight gain |
| __Flat feet | __Sleep problems | __Diarrhea |
| __Nosebleeds | __Canker sores | __Migraines |
| __Bad breath | __Hyperactivity | __Weight loss |
| __Frequent headaches | __Stomach aches | __Dizzy spells |
| __Painful urination | __Changes in appetite | __Motion sickness |
| __Bed wetting | __Itchy anus | __Wheezing |
| __Gas | __Sore throat | __Dry Skin |
| __Parasites | __Congestion | __Nervousness |
| __Bleeding gums | __Itchy nose | __Vomiting spells |
| __Hearing loss | __Teeth grinding | __Eczema |
| __Psoriasis | __Constipation | __Nightmares |
| __Blood in urine | __Itchy vagina |        |
NUTRITIONAL SUPPLEMENTS
Please list any vitamins, herbal and homeopathic supplements your child is currently taking:
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
MEDICATIONS (If any of the following apply, please indicate current or past)

___Antacids
___Antibiotics
___Antidepressants
___Anti-Histamine
___Asthma medications
___Aspirin

___Diclectin
___Decongestant
___Dextroamphetamine (Dexedrine, Dextrostat, Adderall)
___Epilepsy medication
___Ibuprofen

___Inhaled steroids
___Methylphenidate (Ritalin)
___Tylenol
___Other: ____________

Are you aware of any allergies to medications? __________________________
______________________________________________________________________
______________________________________________________________________
IMMUNIZATIONS (Please check all that apply)

___Diptheria
___Influenza
___IPV (Polio)
___DPT
___Measles

___PNEU (Pneumococcal disease)
___Hemophilus
___MENI (Menigococcal disease)
___Small pox
___Hepatitis

___MMR (Measles, Mumps, Rubella)
___Tetanus
___Hib (Hemophilus influenza)
___Mumps
___VAR (Varicella or chicken pox)

Were there any reactions to immunization(s)? If so, please describe: ________________
______________________________________________________________________
______________________________________________________________________
FAMILY MEDICAL HISTORY

Hereditary Diseases:

Use “F” for father, “M” for mother, “S” for sibling, “G” for grandparent, “O” for others:

___Heart Disease
___Diabetes
___Allergies
___Hypertension
___Arthritis
___Mental Illness
___Intestinal Disease
___Osteoporosis

___Alcoholism
___Asthma
___Ulcers
___Gall Bladder Problems
___Kidney Dysfunction
___Cancer, type: ____________
___Other (please describe): ____________
MOTHER’S HEALTH DURING PREGNANCY (please check all that apply)

___ Alcohol use
___ Cigarette smoking
___ Illicit drug use
___ Gestational diabetes
___ Diabetes (type 1 or 2)
___ Stress
___ Anemia
___ Hypertension
___ Thyroid problems
___ Bleeding
___ Nausea
___ Uterine infection
___ Dental problems
___ Physical or emotional trauma
___ Pre-eclampsia
___ Other, please specify: ____________________

MEDICATIONS WHILE PREGNANT: ____________________________________________

MEDICATIONS WHILE NURSING (Mother): ______________________________________

CHILD’S BIRTH HISTORY:
___ Full term   ___ Premature @ ___ weeks   ___ Late ___ @ ___ weeks
Weight at birth __________ lbs.
Length of labour: __________  Any complications? _____________________________
Birth: ___ Vaginal  ___ C-Section  ___ Induced  ___ Forceps  ___ Anesthesia

Medications during or after labor? ____________________________________________

CHILD’S DIETARY HABITS:
Breast fed? Yes/No  If yes, for how long? ______________________________________
Formula fed? Yes/No  When was formula started? ________________________________

When were solid foods first introduced? ______________________________________
What were the first foods introduced? _________________________________________

How many meals a day does your child eat:
Main Meals ___  Times of day: __________________________
Snacks ___  Times of day: __________________________

My child usually eats (please check all that apply):
___ With family  ___ Alone  ___ On the run  ___ At restaurants  ___ Fast food  ___ Too quickly
Are there any dietary restrictions or does your child follow a special diet? If yes, please explain:

________________________________________________________________________________________________

How many ¼ cup servings of each does your child typically eat in a day?:

- Fruit: Fresh _____ Dried _____ Canned _____
- Vegetables: Cooked _____ Raw _____
- Whole Grains: _____ type __________________________
- Protein: _____ type __________________________
- Dairy products: _____ type __________________________
- Good Fats (nuts, seeds, avocado, olive oil, coconut oil): _____ type________________________
- Other: Specify __________________________

Please provide examples of your child's typical meals:

Breakfast: __________________________________________________________________________

Lunch: __________________________________________________________________________

Dinner: __________________________________________________________________________

Snacks: __________________________________________________________________________

Does your child eat or use (Indicate “1” for “rarely”, “2” for “regularly”, “3” for “often”):

  ___ Aluminum pans  ___ Vegetable oils (canola, sunflower, soy, margarine)
  ___ Microwave  ___ Instant/packaged food (Nutra Sweet, Aspartame, Splenda, Equal, etc.)
  ___ Candy  ___ Refined foods (pastry, white bread/pasta/rice, etc.)
  ___ Fried foods

Please indicate how many cups of the following your child drinks per day:

  ___ Tap water  ___ Fruit juices (Prepared)
  ___ Bottled or spring water  ___ Fruit juices (Fresh)
  ___ Soft drinks (Diet)  ___ Tea
  ___ Soft drinks (Regular)  ___ Herbal Tea
  ___ Milk (1%, 2% or whole)  ___ Vegetable juices (Fresh)
  ___ Milk (Skim)  ___ Other

What are your child’s favourite foods and how often is it eaten? ______________________________________

________________________________________________________________________________________

Does your child avoid certain foods? If so, why? ________________________________________________

________________________________________________________________________________________
Does your child experience any symptoms if meals are missed? Explain: ______________________________

____________________________________________________________________________________

Does your child experience any symptoms after meals? Explain: ______________________________

____________________________________________________________________________________

Any other comments: ____________________________________________________________________

____________________________________________________________________________________

FEE SCHEDULE:

Initial visit (60-90 minutes): $297
Follow up visit (45-60 minutes): $149

I understand and agree that all services rendered are charged directly to me and that I am personally responsible for payment. I understand that fees for professional services are due when rendered.

CLIENT STATEMENT:

I understand and acknowledge that the services provided are at all times restricted to consultation on the subject of health matters intended for general well-being and are not meant for the purposes of medical diagnosis, treatment or prescribing of medicine for any disease, or any licensed or controlled act which may constitute the practice of medicine. This statement is being signed voluntarily.

Client name: ________________________________________________________________

Name of parent (please print): ________________________________________________

Signature of parent: ___________________________ Date: ________________________

Thank you for your cooperation.

All information contained in this form will be kept strictly confidential.
# Seven Day Food Diary

Please roughly record your typical intake for 7 days  

Client: ___________________________  Date: __________

<table>
<thead>
<tr>
<th>Meal</th>
<th>Sunday</th>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
<th>Saturday</th>
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<tbody>
<tr>
<td>Breakfast</td>
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<tr>
<td>Mid Morning Snack</td>
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<td>Lunch</td>
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<td>Mid Afternoon Snack</td>
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<td>Dinner</td>
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<td>Evening Snack</td>
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<tr>
<td>Noticeable symptoms - physical or emotional</td>
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