IMPULSE HEALTH AND WELLNESS

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Pediatric Nutrition Intake Form

(For children up to the age of 12 years)

For office use only:

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 _____

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? _____ 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: _____

For office use only:

Hospitalized? Reason: _____

For office use only:

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:

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

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

For office use only:

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
___Dextroampehtamine (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 (Pneumoccocal 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)

For office use only:

___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:

_____

For office use only:

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
___ Microwave
___ Candy
___ Fried foods
___ Vegetable oils *(canola, sunflower, soy, margarine)*
___ Instant/packaged food
___ Refined foods *(pastries, white bread/pasta/rice, etc.)*
___ Luncheon/Deli meats
___ Artificial sweeteners *(Nutra Sweet, Aspartame, Splenda, Equal, etc.)*

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

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

What are your child's favourite foods and how often is it eaten? _____

_____

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

_____

For office use only:

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: _____**

Meal	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Breakfast							
Mid Morning Snack							
Lunch							
Mid Afternoon Snack							
Dinner							
Evening Snack							
Noticeable symptoms – physical or emotional							