

## Dietitian History Questionnaire and Assessment (Pediatrics)

### General Information:

Child's Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Parents'/Care Givers' Name(s): \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Phone #2: \_\_\_\_\_ Email: \_\_\_\_\_

Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Gender: \_\_\_\_\_

Reason for Appointment: \_\_\_\_\_

Primary Care Provider: \_\_\_\_\_

Address/Phone: \_\_\_\_\_

Therapist: \_\_\_\_\_

Address/Phone: \_\_\_\_\_

Referred by: \_\_\_\_\_

Grade in School: \_\_\_\_\_ Name of School: \_\_\_\_\_

Parent's Marital Status:  Single  Married  Divorced  Separated  Widowed

Parent's Occupation(s): \_\_\_\_\_

Siblings: Brother(s): \_\_\_\_\_ Ages: \_\_\_\_\_ Sister(s): \_\_\_\_\_ Ages: \_\_\_\_\_

### Medical History:

Height: \_\_\_\_\_ Current Weight: \_\_\_\_\_

Growth History: \_\_\_\_\_

Are you concerned with your child's weight?  Yes  No

Mother's Height: \_\_\_\_\_ Father's Height: \_\_\_\_\_

Are you concerned with your own weight?  Yes  No

Birth Weight: \_\_\_\_\_ Breast fed? \_\_\_\_\_ How long? \_\_\_\_\_

Bottle fed? \_\_\_\_\_ How long? \_\_\_\_\_ Formula: \_\_\_\_\_

Early feeding problems: \_\_\_\_\_

At what age were foods first introduced? \_\_\_\_\_

List complications: \_\_\_\_\_

Food allergies/intolerances as an infant/toddler?  Yes  No

Please specify: \_\_\_\_\_

Symptoms: \_\_\_\_\_

Normal Pregnancy?  Yes  No List complications: \_\_\_\_\_

Normal Delivery?  Yes  No List complications: \_\_\_\_\_

Normal Growth/Development?  Yes  No List complications: \_\_\_\_\_

**Please indicate whether your child or a family member have/had any of the following conditions:**

<b>Disease/Condition</b>	<b>Child</b>	<b>Family</b>	<b>Relationship</b>	<b>Treatment</b>
Asthma	_____	_____	_____	_____
Cancer	_____	_____	_____	_____
Cardiovascular Disease	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____
Drug Dependency	_____	_____	_____	_____
Eating Disorder	_____	_____	_____	_____
Food Allergies	_____	_____	_____	_____
Food Intolerances	_____	_____	_____	_____
Kidney Disease	_____	_____	_____	_____
Headaches	_____	_____	_____	_____
Heart Attack	_____	_____	_____	_____
High Cholesterol	_____	_____	_____	_____
Hypertension	_____	_____	_____	_____
Intestinal Problems	_____	_____	_____	_____
Menstrual Problems	_____	_____	_____	_____
Mental Health Issues	_____	_____	_____	_____
Obesity	_____	_____	_____	_____
Osteoporosis	_____	_____	_____	_____
Other _____	_____	_____	_____	_____

List any medications your child is taking or has taken in the last year: \_\_\_\_\_

Is your child currently taking any food supplements, vitamin, mineral, or herbal supplements? \_\_\_ Yes \_\_\_ No

If yes, please specify: \_\_\_\_\_

**Menstrual History:** (Female Patient):

Age began menstruating: \_\_\_\_\_ years of age \_\_\_\_\_ Have never menstruated

Date of last menstrual cycle: \_\_\_\_\_ Weight at that time: \_\_\_\_\_ pounds

**Dieting History:**

Has your child ever dieted? \_\_\_ Yes \_\_\_ No How many diets has your child been on? \_\_\_\_\_

Age of first diet: \_\_\_\_\_ years Weight at that time: \_\_\_\_\_ pounds

Why did your child go on the diet? \_\_\_\_\_

**Exercise History:**

Does your child currently exercise/participate in sports? \_\_\_ Yes \_\_\_ No

Type, duration, frequency, and intensity of exercise activities: \_\_\_\_\_

What types of physical activities does your child enjoy?

\_\_\_\_\_

**Eating Habits:**

How many days per week does your child eat:

Breakfast: \_\_\_\_\_ Lunch: \_\_\_\_\_ Dinner: \_\_\_\_\_ Snacks: \_\_\_\_\_

When does your child usually snack? \_\_\_\_\_

Does your child eat out (restaurants, take-out, fast food, etc.)? \_\_\_ Yes \_\_\_ No

How often? \_\_\_\_\_

List restaurants usually chosen: \_\_\_\_\_

Does your child take lunch to school or buy lunch at school? \_\_\_\_\_

Examples of food choices: \_\_\_\_\_

Does your child eat snacks at school? \_\_\_ Yes \_\_\_ No What?

Who is responsible for grocery shopping? \_\_\_\_\_

Who prepares/cooks the meals? \_\_\_\_\_

Do you read food labels? \_\_\_ Yes \_\_\_ No What do you look at on the label? \_\_\_\_\_

Does your child eat standing up, walking, etc.? \_\_\_\_\_ Yes \_\_\_ No

Does your child eat in the car, on the bus, etc.? \_\_\_\_\_ Yes \_\_\_ No

Does your child eat in front of the TV? \_\_\_\_\_ Yes \_\_\_ No

Does your child eat while reading, on the computer, etc.? \_\_\_\_\_ Yes \_\_\_ No

Does your child eat with others? \_\_\_\_\_ Yes \_\_\_ No

Does your child eat faster/slower than others? \_\_\_\_\_ Yes \_\_\_ No

Does your child eat when stressed/bored/lonely? \_\_\_\_\_ Yes \_\_\_ No

Does your child feel bad after eating? \_\_\_\_\_ Yes \_\_\_ No

Does your child sneak food/hide food? \_\_\_\_\_ Yes \_\_\_ No

Does your child wish others wouldn't comment on what he/she ate? \_\_\_\_\_ Yes \_\_\_ No

Does your child feel like he/she eats differently than others? \_\_\_\_\_ Yes \_\_\_ No

Describe: \_\_\_\_\_

Does your child know what hunger & fullness feel like? \_\_\_\_\_ Yes \_\_\_ No

Does your child prepare his/her own meals? \_\_\_\_\_ Yes \_\_\_ No

Does your child avoid certain foods? \_\_\_\_\_ Yes \_\_\_ No

Please specify: \_\_\_\_\_

What are your child's favorite foods? \_\_\_\_\_

What food does your child dislike? \_\_\_\_\_

Please list your main concerns about your child's nutritional intake: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Family Weight History:**

Are any members of your family overweight?  Yes  No Explain: \_\_\_\_\_

Are any members of your family underweight?  Yes  No Explain: \_\_\_\_\_

Does anyone in your family diet?  Yes  No Explain: \_\_\_\_\_

Did/Does anyone in your family have an eating disorder?  Yes  No  
Explain: \_\_\_\_\_

Does your family eat meals together?  Yes  No Which meals? \_\_\_\_\_