
**Children's Nutritional Intake Form**

Name of child:

Name of parent:

Address:

E-mail:

Cell #:

Age of child: Date of Birth:

Current Weight:

Weight 6 months ago:

Weight 1 year ago:

Siblings & Ages:

Any known food allergies for child?

Any known food allergies for siblings or parents?

Is the child in school? If yes, what grade?

What does a typical weekday schedule look like for your child?

Does your child take any supplements or medications? If so, which?

How is the health of the child's mother?

How is the health of the child's father?

**Please list your Health Goals for your child:**

_____

_____

**Lifestyle History**

1. How many glasses of water does child drink per day and what is the source (tap, bottled, etc)? _____

2. Please list other drinks & quantity per day (i.e. juice, milk, etc):_____
   _____

3. What is your child's relationship with sugar? ___eat daily___ occasionally___ rarely ___never ____
   a. Have you noticed any side effects?

4. Does child use artificial sweeteners? If so, which one?_____ How often/week?_____

5. How often does child have bowel movements _____daily _____weekly

6. Does child have any trouble with _____constipation _____ diarrhea_____or both. How long has this been a problem?_____

7. How would you rate child's energy level on a scale of 1-10 (10 being the highest)? _____
   Has this changed over the past year (s)? Please explain:
   _____
   _____

**Food Lifestyle**

1. Please use this page to help me understand child's current eating patterns. This really helps me focus on likes, dislikes, patterns, strengths, and gaps.
   SKIP THIS TABLE IF FILLING OUT A FOOD DIARY

| **Meal Part** | **Foods Consumed** |
|---|---|
| Breakfast | |
| Snack | |
| Lunch | |
| Snack | |
| Dinner | |

   a. What % of child's food is home cooked? ____
   b. Where else is child eating (restaurants, prepared foods section, etc?
      _____
   c. Does child have times of the day when you are most hungry? _____
   d. How often does the family eat out, or pick up take-out during the week?_____ Weekends? _____
   e. What foods would I always find in family's cupboard?
      _____
      _____

f. What foods would I always find in family's refrigerator?
_____
g. _____
h. Where does family shop? How often? When? _____
i. Does parent (s) enjoy cooking? Y / N If No, why not?
_____
j. Do you read nutritional panels? Y / N
k. Are you interested in a grocery store tour? Y / N
l. Check all that apply when deciding what to buy:
    - 1. Taste
    - 2. Price
    - 3. Nutrition
    - 4. Ease of Preparation
m. Have parents read any nutritional books? Which ones?

2. Daily Nutrition

a. Child eats fresh fruit: ___ daily ____occasionally ____seldom
b. Child eat fresh vegetables: ____daily ____occasionally ____seldom
c. The wheat, rice, and pasta child typically eats are: ____ refined, white ____ whole grain, coarse
d. The dairy products child typically eats are: ___full fat ____low fat ____ skim ___I don't typically eat dairy products
e. Does child eat soy products? If so, how many servings/week and what products?_____
f. The meats child typically eats are: ____high fat (prime beef, hamburgers)
g. ____medium fat (lean red meat, chicken with skin) ____lean (fish, white meat chicken/turkey)___I don't eat meat
h. Does child eat fried foods, including fast foods: ___often ____occasionally ____seldom ____never
i. Do you feel child's diet is deficient in some way?_____
j. Do you feel child's diet is excessive in some way?_____
k. What are child's 3 favorite foods in the following categories:
    1. Favorite fruits _____
    2. Favorite vegetables _____
    3. Favorite meats / seafood _____
    4. Favorite grains _____
    5. Favorite dairy _____
    6. Favorite snacks _____

**Health Goals:**

1. Is your child's health currently getting better, worse, or staying the same? How do you know?

2. What have you tried to improve child's health (i.e. doctor visits, alternative treatments, other treatments, etc.)

3. For our time together to be a **true win**, what do you want to accomplish over the course of our time together?

4. How long do you think it will take?

5. What is your family's level of **commitment** to change the underlying causes of problem (s) which relate to your lifestyle from 1-10 (with 10 being 100%)?

6. What **obstacles** could prevent your family from changing those lifestyle habits that undermining your family's health?