Pediatric Nutrition Assessment

Today's Date: ____/____/20___

Child Name: _____ **Child Date of Birth:** ____/____/_____ **Child Age:** _____

Parent/Guardian Name: _____ **Parent Phone #** _____ **Parent Email:** _____

Section 1: Parent/Child please complete the following regarding the child.

Please list any medical diagnoses:

Please list any medications, vitamins, or supplements your child is currently taking:

YES NO Has your child experienced abnormal levels of unintentional weight gain or loss over the past year?

YES NO Are you concerned about your child's height and/or growth?

YES NO Does your child have a condition that requires a special diet?

YES NO Does your child have any food allergies or intolerances?

YES NO Does your child avoid multiple food groups?

YES NO Does your child suffer from any digestive problems at least once per week (constipation, vomiting, reflux, gas/bloating, diarrhea/loose stools, etc.)?

YES NO Does your child participate in a sport for 10 or more hours per week?

For children 8 years and older, please have the child answer the following:

YES NO Are you satisfied with your weight?
If you answered "no", do you want to weigh more or less than you currently do? _____

Referral to Dietitian for further treatment recommended? ***YES NO***

If YES, list concerns:

RD Signature: _____ Date: _____

Food Frequency Inventory: How often, in the past 3 months, did your child eat the following? (check the appropriate box for each row)	*Never*	*< 1x/week*	*1-3x/week*	*4-6x/week*	*1x/day*	*2-3x/day*	*4+/day*
Fruit: (apples, bananas, melon, berries, oranges, etc.)							
Vegetables, non-starchy: (carrots, broccoli, lettuce, etc.)							
Vegetables, starchy: (corn, peas, potatoes)							
Beans: (beans, tofu, chickpeas, other legumes)							
Nuts: (peanuts, almonds, cashews, walnuts, etc.)							
Refined Grains: (white bread, pasta, white rice, crackers, cereal, etc.)							
Whole Grains: (whole wheat bread, oats, quinoa, bran, etc.)							
Chicken: (roasted, grilled, nuggets, in soup, etc.)							
Turkey: (sandwich, dinner, in soup, etc.)							
Fish & Seafood: (tuna, shrimp, crab, salmon, etc.)							
Pork: (ham, chops, ribs, etc.)							
Beef: (steak, burgers, roast, hot dog, etc.)							
Other Meats: (duck, lamb, venison, etc.)							
Eggs: (omelet, in salads, in baked goods, etc.)							
Dairy: (cheese, milk, yogurt, etc.)							
Salty Snacks: (chips, pretzels, popcorn, etc.)							
Other Shacks: (granola bars, energy bars, fruit snacks, etc.)							
Sweets: (candy, cookies, pie, ice cream, etc.)							
Condiments/Extras: (butter, oil, dressing, ketchup, sauce, etc.)							
Caffeinated Soft Drinks: (cola, diet cola, energy drinks, etc.)							
Coffee & Tea Beverages:							
Other Drinks: (juice, fruit drinks, sport drinks, etc.)							
Water:							

Many of our clients are eligible for nutrition services through their medical insurance.
If your insurance does not cover nutrition services, present this assessment at your first visit and enjoy a 20% discount off the cost of your initial appointment!