



THE CENTER FOR ADVANCED PEDIATRICS

Comprehensive Care for Infants, Children & Young Adults

Date _____ **Please bring this form to your first NUTRITION appointment**

Child's Name _____ M F Date of Birth _____

Who is your child's Primary physician? _____

Parents Names _____ S M D
Mother Father

Address _____

Home Tel # _____ Cell # _____ Email _____

1. Please list your ethnic background? (for purpose of determining health risk factor) _____

2. How are you hoping to benefit from this nutrition session?

3. What are your feeding concerns and health concerns? Attach additional paper if necessary.

4. Does your child have any food allergies or other allergies? Yes / No epi-pen
Please List _____

5. Does your child have any food intolerances? Yes / No
Please Explain _____

6. Does your child have any food texture challenges? Yes / No
Please Explain _____

7. Does your child have any swallowing concerns? Yes / No
Please Explain _____

8. Does your family have cultural or religious food preferences? Yes / No
Please Explain _____

9. Please list any medical concerns/surgeries/ or family changes recently:

10. List any medications &/or supplements that your child presently takes and reason prescribed

BEVERAGES

11. Circle all beverages your child drinks

only flavored milk water juice milk soda reg/diet gatorade other_____

12. Underline all kinds of drinking containers your child uses

sippy cup baby bottle straw cup glass juice box other_____

MILK

13. Does your child drink milk? Yes / No

Circle which kind

cow's milk skim 1% 2% Whole Soy Rice

14. Circle the milk serving size most often served if by the glass?

4oz 6oz 8oz 10oz 12oz 16oz

15. How many times is milk served per day? Never 0-1 1-2 2-3 3-4 4+ only in cereal

PROTEIN

16. Underline protein items that your child eats

Chicken Beef Fish Tuna fish Peanut butter Beans Tofu Eggs Cheese Soy

FRUIT

17. How many times does your child eat fruit?

Per Day -- Never 0-1 1-2 2-3 3-4 5+

Per Week -- Never 0-1 1-2 2-3 3-4 5+

VEGETABLES

18. How many times does your child eat vegetables?

Per Day -- Never 0-1 1-2 2-3 3-4

Per Week -- Never 0-1 1-2 2-3 3-4 5+

GRAINS/ BREADS

19. Underline which item(s) your child will eat:

white bread whole wheat bread white rice cereal waffles pancakes brown rice
pasta bagel english muffins tortilla other_____

FATS

20. Underline what kind of fat spread you use?

Butter stick margarine tub margarine olive oil vegetable oil

How often? Each meal Only on certain foods Cooking only

ACTIVITY

21. How many hours of TV watching _____ per day? Video Games _____ per day?

22. Time on computers? _____ per day? Is there a television in the bedroom? Yes No

23. What time does your child go to sleep at night? _____ Wake? _____ Nap? _____

24. Does your child participate in team sports? Yes No What sports?

25. What other type of activities does your child enjoy doing?

SAMPLE FOOD CHOICES

26. How often does your child eat in restaurants or take out? _____ times / week _____ per month

Where do you go? _____

27. Please list 2-3 cereals that your child eats. _____

28. Please list **all** snack choices available to your child throughout the week. Please include any served by day care, school, after-school programs, relatives' homes, and in home cabinets.

29. Please list food choices that your child likes to eat for breakfast, lunch, and dinner:

BREAKFAST

LUNCH

DINNER



Additional Info
