BRG Dietetics & Nutrition, P.C.
Bonnie R. Giller
MS, RDN, CDN, CDE
Registered Dietitian Nutritionist
Certified Diabetes Educator
Certified Intuitive Eating Counselor

Pediatric Nutrition Assessment Form

Name_____ Date_____

Address_____ Birthdate_____ Age_____

_____ Sex_____

Mother's Name_____ Father's Name_____

Phone (home)_____ (work)_____ (cell)_____

E-mail _____

Siblings:_____

Medical History

Pediatrician _____ Address _____

Phone _____ _____

Date of child's last check up _____

Is your child up to date with his/her shots (vaccinations)? ☐Yes ☐No ☐ Don't know

Does your child have any medical problem(s)? ☐Yes ☐No
Please describe _____

_____

Has your child received medical treatment for any health problems during the last six months? ☐Yes ☐No
Please describe _____

_____

Past Hospitalization(s)_____

Medications (List all)_____

_____

Does your child take any of the following?

	Yes	No	What kind?	How often?
Vitamins	☐	☐	_____	_____
Iron	☐	☐	_____	_____

Does your child have any food allergies? ☐Yes ☐No

What food(s)? _____

Dental History:

Has your child had a dental check-up in the past 12 months? ☐Yes ☐No

Does your child brush their teeth? ☐Yes ☐No

Does your child have any dental problems? ☐Yes ☐No

Family Medical History:

Check items that apply to your child's blood relatives, brothers, sisters, parents, and grandparents (list whom next to each box checked).

☐Alcohol/Substance Abuse
☐Cancer
☐Diabetes
☐Depression/Mental illness
☐Food sensitivity
☐Other allergies
☐Heart disease or Stroke
☐High blood pressure
☐Hyperlipidemia
☐Obesity
☐Smoking
☐Thyroid dysfunction

Growth History:

Current Height_____ Current Weight_____ Birth Length_____ Birth Weight_____

In the past month has your child: ☐Lost weight ☐Gained weight # lbs lost/gained:_____ ☐No change

If you lost weight was it: ☐Intentional ☐Unintentional Explain:_____

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Nutrition Assessment

Please check the correct box or write in your answers to the following questions:

1. Do you have any cultural / religious practices or beliefs that influence your diet? ☐Yes ☐No
   If yes, please describe _____

2. How would you describe your child's appetite:
   ☐Good ☐Fair ☐Poor
3. Does your child have any food dislikes? ☐Yes ☐No
   If yes, list: _____

4. How many times a day does your child drink the following?
   Water ____ Soda ____ Sweet tea ____
   Juice ____ Punch ____ Fruit drinks ____

5. Who prepares meals for your child?
   Breakfast_____
   Lunch _____
   Dinner _____
   Snacks _____

6. Who decides when your child is finished eating? ☐ Child ☐ Parent ☐Other _____

7. What is done when your child does not want to eat all or most of the food that is on their plate?
   _____

8. What is done if your child wants seconds of a food? _____

9. Do you feel your child eats when they're not hungry?
   ☐ Yes, several times per day
   ☐ No
   ☐ Unable to determine

10. How many times per week does your family eat meals together?
    ☐ Less than 5 ☐ 5-7 times ☐ 7-10 times ☐ 10 or more times

11. Does your family typically eat meals and snacks in front of the television, iPad or other electronics?
    ☐ Yes ☐ No ☐ Sometimes

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Regular Exercise: ☐Yes ☐No

Type: _____ #Times/Week: _____

_____ #Minutes/Session: _____

_____

(i.e.) baseball, basketball, bicycle riding, roller skating, gymnastics, skateboarding, jumping rope

Has your child ever been seen by a Registered Dietitian Nutritionist? ☐Yes ☐No

If yes: Who _____ When? _____

Why: _____

List any nutrition goals you hope you child will achieve as a result of nutrition counseling:

_____

_____

_____

_____

_____