



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	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Iron	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

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).

- | | |
|--|--|
| <input type="checkbox"/> Alcohol/Substance Abuse | <input type="checkbox"/> Heart disease or Stroke |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hyperlipidemia |
| <input type="checkbox"/> Depression/Mental illness | <input type="checkbox"/> Obesity |
| <input type="checkbox"/> Food sensitivity | <input type="checkbox"/> Smoking |
| <input type="checkbox"/> Other allergies | <input type="checkbox"/> 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: _____

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

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:
