Hunterdon Health
Center for Nutrition & Diabetes Management
Wescott Medical Arts Building
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Pediatric Nutrition Self-Assessment

Please fill out all of the information on this form and bring it to your nutrition appointment.
(Please use a pen. Do not use pencil.)

Child's Name: _____Today's Date: _____

Pediatrician/PCP: _____Other Referring Physician: _____

List any medication your child takes:

Medication: _____ Dose:_____

Medication: _____ Dose:_____

Vitamins/Minerals:

Multi vitamin: _____ Dose:_____ Calcium: _____ Dose:_____

Herbal supplements: _____ Dose:_____ Other: _____ Dose:_____

List any food and/or drug allergies _____

_____

Medical History: (please circle those that apply)

Diabetes Pre-Diabetes Family History Diabetes Overweight/Obesity High Cholesterol

High Blood Pressure Eating Disorder Celiac Disease Anemia Polycystic Ovarian Syndrome (PCOS)

Irritable Bowel Syndrome Ulcer Colitis/Crohn's Disease Others: _____

Exercise:

1. Does your child exercise regularly? ☐ Yes ☐ No
   If yes, how often? _____For how long? _____
2. Type of exercise: _____
3. How many days a week does your child have gym? _____
4. Any exercise limitations?_____
5. List after school activities your child attends _____

Learning Style:

1. Learning Preference: ☐ Reading ☐ Discussion ☐ Internet ☐ DVD/CD ☐ Hands on training
2. Do you or your child use a Smart Phone/Tablet? ☐ Yes ☐ No

   If yes, have you or your child used a nutrition or any physical activity apps? ☐ Yes ☐ No
3. Has your child had previous nutrition education? ☐ Yes ☐ No
   If yes, where? _____and how long ago?_____

Parent:

1. Do you have any problems learning about medical conditions because of difficulty understanding written information? ☐ Yes ☐ No
2. Are you confident in filling out medical forms independently? ☐ Yes ☐ No

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The most important things we want to learn today are:

1. _____
2. _____
3. _____

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1. Does your child have any religious or cultural observations that affect how they eat?
   ☐ Yes ☐ No If yes, please explain _____
2. Does your child feel deprived regarding food and meals? ☐ Yes ☐ No
3. Does your child feel uncomfortable in social situations related to food? ☐ Yes ☐ No
4. Does your child constantly feel concerned about food and eating? ☐ Yes ☐ No
   If yes, please explain _____

_____

Intake History:

1. Who prepares your child's meals?_____
2. How are the kids meals usually prepared? ☐ Fried ☐ Baked ☐ Grilled ☐ Broiled
3. How many times a week do you eat away from home?_____a week.
   ☐ Fast Food ☐ Restaurant ☐ Take Out ☐ Other_____
4. Does your child: ☐ Skip meals ☐ Nibble between meals ☐ Eat rapidly ☐ Have cravings
   ☐ Use convenience foods ☐ Eat unplanned meals ☐ Other_____

Based on one day:

1. How much milk or yogurt does your child consume? _____How many vegetables? ____
2. How many fruits? ____How much water does your child drink in one day?__ oz. or glasses
3. What does your child usually drink? _____

Name: _____Date of Birth: _____

Height: _____Current Weight: _____

Usual Body Weight: _____Goal Weight:_____

Please record your food intake. What kind of food? How much food?

BREAKFAST **TIME:_____**	**MORNING SNACK** **TIME:_____**
LUNCH **TIME:_____**	**AFTERNOON SNACK** **TIME:_____**
DINNER **TIME:_____**	**EVENING SNACK** **TIME:_____**

_____RD DATE: _____

Notes/Comments: _____

_____

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