



Pediatric Nutrition-New Patient Form

Child's Name: _____

Sex: **M** **F**

DOB: _____ DOV: _____

Chief complaint/Reason for referral: _____

Who sent you to see the nutritionist:

Food/Nutrition Related History

Birth & Feeding History (if under 3 years old):

Birth Weight: _____ lbs. _____ oz

Birth Length: _____ inches

Full Term: _____ Yes/no

Breast Fed: _____ Yes/no

If Yes, until what age/ _____

Formula Fed/what formula?

Age solid foods were introduced: _____

Does your child have a good appetite?

Who does the family cooking and grocery shopping?

How many meals does the family eat per week?

How long do meals last?

Is this a problem for the family? _____ Yes/no

Has the patient changed his/her diet recently? _____ Yes/no

Previous diet/nutrition education/counseling? _____ Yes/no

Does the patient follow a special diet? _____ Yes/no

Which food groups does he/she try to avoid?

Yes/no

Is child or adolescent experiencing mealtime behavioral problems or changed behavior lately? Yes/No:

Growth Data: Provide as many heights and weights as possible:

Date	Weight	Height

Social History:

Who does the child live with?

If shared custody, what is the living arrangement? _____

Who lives at home?

Name	Ages

Is your child in Daycare/after school program?

Yes/No

Fulltime or part time? _____

If your child is not in daycare who care for him/her during the day?

Do you receive WIC benefits?

Yes/No

Does your child receive free/reduce lunch?

Yes/No

What grade is your child in?

How are they doing in school?

Any special education needs in school?

Yes/No

How many hours per day does your child watch TV?

How many hours per day does your child play video games or is on the computer?

How many hours per day does your child active (riding bike, playing outside, sports)?

Does your child participate in an organized sport?

What sport does your child participate in?

What does your child do in the summer time?

Medical History, Tests, Lab Data:

Food Allergies:

When & how were they diagnosed?

Pertinent Labs/Studies:

How often does your child have a bowel movement? _____ per day _____ per week

Any problems with? Constipations Diarrhea Flatulence
Abdominal Pain

Has the patient ever been told he/she has an eating disorder?
Yes/No

Has the patient ever received professional help for eating/feeding problems?
Yes/No

Changes in Medical Hx:

Menses: _____ At what age? _____ Are they regular? Yes/No

Medications:

Vitamin /Mineral/Herbal Supplement:

Is the patient taking any oral contraceptives?
Yes/No

Pertinent Family Medical History: (Parents, siblings, grandparents) Please circle all that applies.

Does anyone suffer from?

Disease	Yes	No	Family Member
Cancer	Y	N	
Cystic Fibrosis	Y	N	
Celiac Sprue Disease	Y	N	
Gastoespohageal Reflux	Y	N	
Constipation	Y	N	
Crohn's Disease	Y	N	
Diabetes	Y	N	
Early Heart Disease	Y	N	
Eating Disorder	Y	N	
Food Allergies	Y	N	
High Blood Pressure	Y	N	
High Cholesterol	Y	N	
Obesity	Y	N	

Father's Height: _____

Mother's

Height: _____

What is your family's ancestry/ethnic background? _____

Sleep History

Sleep Habits: How many hours does your child sleep each night? _____

How do you feel about the amount of sleep your child gets?

Sleep Changes:

Doctors Involved in your child's healthcare

Name/Type of
Doctor: _____

Address/Phone: _____

Name/Type of
Doctor: _____

Address/Phone: _____

Name/Type of
Doctor: _____

Address/Phone: _____

Name/Type of
Doctor: _____

Address/Phone: _____

Name/Type of
Doctor: _____

Address/Phone: _____
