BLUEPRINT NUTRITION
Registered Dietitian Services

New Hamburg Office: Affinity Health Clinic
3 Waterloo St., New Hamburg, ON
www.blueprintnutrition.ca
rosanne@blueprintnutrition.ca
519.574.3614

Nutrition and Health History Form - PEDIATRIC

The following questionnaire is intended to help me gain a full understanding of your child's nutrition needs. Please do not feel obligated to fill out any questions that you do not feel comfortable answering or are not applicable to your nutrition concerns.

CONTACT & BACKGROUND INFORMATION

<table>
<tr><td>Child's Name:</td><td>Child's Gender:</td><td>Date:</td></tr>
<tr><td>Address:
City:
Postal code:</td><td colspan="2">DOB: (day/month/year)

Age:</td></tr>
<tr><td>Caregiver's home/cell phone:</td><td colspan="2">Caregiver's fax:</td></tr>
<tr><td>Caregiver's work phone:</td><td colspan="2">Email: (if given, verifies consent to email)</td></tr>
<tr><td>Caregiver's occupation:</td><td colspan="2" rowspan="2">Child's Primary Doctor - name:
Address:
City:
Phone number:
Fax number:</td></tr>
<tr><td>Caregiver's marital status:
Child's siblings & ages:</td></tr>
<tr><td>How did you hear about us?</td><td colspan="2">Preferred method of communication: (i.e. email, cell phone, text message etc.)</td></tr>
<tr><td colspan="3">Would you like your physician to receive a copy of my assessment?</td></tr>
</table>

Nutrition questions, goals, concerns you would like to discuss:

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MEDICAL HISTORY

CONDITION	CHILD'S	FAMILY	Details
Anemia (low iron)			
Anorexia/bulimia/binge eating disorder			
Allergies (please note if allergy is anaphylactic)			
Cancer			
Celiac Disease			
Depression/anxiety/psychiatric care			
Diabetes			
Digestive issues/disease (including cramps, bloating, bowel irregularity)			
Epilepsy or seizures			
Fatigue/sleepiness			
Food allergies			
Food intolerances			
Frequent headaches/migraines			
Frequent colds/flu/coughs			
Heart disorder/heart attack/stroke/angina			
High cholesterol			
Hyperglycemia (high blood sugars)			
Hypertension (high blood pressure)			
Hypoglycemia (low blood sugars)			
Joint/back pain/injury			
Kidney disease			
Lung disease/asthma			
Osteoporosis			
Overweight/obesity			
Sleep apnea/insomnia			
Surgery			
Thyroid problems			
Weight loss (unintentional)			
Other			
Other			

Medications and Supplements: *(Please list name, dose, indication for use)*
i.e. Jamieson Vitamin D3, 400 IU, once daily

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NUTRITION HISTORY

Current Height:	Current Weight:
Other known heights and weights: *(birth, and significant markers thereafter)*	
Current food restrictions/avoidances:	Does your child follow a specific diet? *(i.e. dairy-free, gluten-free, vegetarian)*
How many times per week does your child eat breakfast? How many times per week does your child eat lunch? How many times per week does your child eat supper? How many snacks per DAY does your child eat? When?	
Number of times a week your child eats out & where:	
What does your child drink for fluids during the day? *(i.e. water, pop, juice, coffee, tea, sports drinks)*	
Who does grocery shopping in your house?	
Who does the cooking in your house?	
How much time do you devote to meal prep/cooking?	
How would you describe your child's relationship with food? *(i.e. fuel for the body, enjoyment, hate)*	
Is food used as a punishment, reward, or bartering tool?	

LIFESTYLE HISTORY

Average hours of sleep during the day: (i.e. naps)
Average hours of sleep at night:
Energy level (1 = low, 10 = high)
Active or sedentary:
Activities/Fitness: (i.e. in which types of activities does your child participate?)

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OTHER INFORMATION

Have you put your child on diets, nutrition programs, or had any other nutrition counselling in the past? If so, please indicate what worked and what didn't work.
Is there anything else you would like to share or feel I should know to ensure our successful partnership?

READINESS RULER – Parent/Caregiver

How ***important*** is it for you to make a change to your child's lifestyle, on a scale of 1 to 10? (1 = low, 10 = high)
How ***confident*** do you feel that you can help to make changes to your child's lifestyle, on a scale of 1 to 10? (1 = low, 10 = high)

READINESS RULER – Child *(if applicable)*

How ***important*** is it for you to make a change to your lifestyle, on a scale of 1 to 10? (1 = low, 10 = high)
How ***confident*** do you feel that you can make changes to your lifestyle, on a scale of 1 to 10? (1 = low, 10 = high)