Nutritional Assessment Questionnaire for Children

Name: _____ **Date:** _____/____/_____

Birthdate: _____ **Age:** _____ **Gender:** _____

Weight: _____ **Height:** _____ **Percentile:** _____

Please list your three major health concerns in order of importance:

1. _____
2. _____
3. _____

Please share three of your child's strongest attributes:

1. _____
2. _____
3. _____

FAMILY BACKGROUND

1. Yes ❒ No❒ Has there been family stress or family conflict?
2. Yes ❒ No❒ Has there been a recent job change in the family?
3. Yes ❒ No❒ Has there been a divorce in the family?
4. Yes ❒ No❒ Does any family member work over 60 hours/week?
5. Yes ❒ No❒ Any family history of diabetes, kidney disease or asthma?
6. Yes ❒ No❒ Any family history of heart disease, arthritis, or gallbladder disease?
7. Yes ❒ No❒ Any family history of cancer? If yes, type of cancer:_____
8. Yes ❒ No❒ Any family history of stomach/intestinal disorders?
9. Yes ❒ No❒ Have any family members ever been affected by substance use or abuse issues?
10. Yes ❒ No❒ Has the child experienced recent changes -- births, deaths, divorce, remarriage, moves?

PRENATAL HEALTH

11. Yes ❒ No❒ Any difficulties/stresses/illnesses during pregnancy?
12. Yes ❒ No❒ Any medication taken during pregnancy? _____
13. Yes ❒ No❒ Any maternal history of Candida or bacterial infection that you are aware of?
14. Yes ❒ No❒ Any alcohol, tobacco or drug use during pregnancy?
15. Yes ❒ No❒ Mercury exposure during pregnancy (tuna/swordfish/sea bass consumption; dental work)
16. Yes ❒ No❒ Non-vaginal delivery? If yes, did you have forceps/vacuum?_____
17. Yes ❒ No❒ Was baby delivered prematurely? If yes, how many weeks_____
18. Yes ❒ No❒ Were there any complications during delivery? _____
19. Yes ❒ No❒ Any medical problems at or immediately following birth? _____
20. Yes ❒ No❒ Any post-partum depression or psychosis?

HEALTH HISTORY

21. Yes ❒ No❒ Did your child walk early (before 12 months)? If yes, what age?_____
22. Yes ❒ No❒ If an early walker, did your child skip the creep/crawl stage?
23. Yes ❒ No❒ Did your child have any difficulty running (forward or backward)?
24. Yes ❒ No❒ Any early toileting issues like diaper rash, frequent diarrhea or constipation?
25. Yes ❒ No❒ Did your child experience colic or inconsolable crying?
26. Yes ❒ No❒ Any early stomach upset, like frequent spit up or vomiting?
27. Yes ❒ No❒ If vaccinated, did your child have any adverse reactions to vaccinations?
28. Yes ❒ No❒ Has your child ever experienced eczema, dry skin or rashes?
29. Yes ❒ No❒ Any cavities? If yes, how many?_____ At what age(s)_____
30. Yes ❒ No❒ Has your child ever experienced a head injury, loss of consciousness, or seizure?
31. Yes ❒ No❒ Does your child have any chronic medical problems?_____
32. Yes ❒ No❒ Any serious injuries, surgeries or medical hospitalizations?_____
33. Yes ❒ No❒ Is child currently taking any medicine or vitamins? Please list _____

FOODS MY CHILD EATS: Please place an X in the appropriate column

FOOD	Daily	3-5 times per week	1 -3 times per week	Never or Almost Never	Used to eat, but not anymore
Artificial sweeteners					
Candy, desserts, sugar					
Carbonated beverages					
Caffeinated beverages					
Essential fatty acid rich foods (avocados, flax seeds)					
Fruit Juice					
Fast foods					
Soy (tofu, veggie burger)					
Low fat foods					
Margarine					
Milk products:					
Chocolate milk					
Whole Milk					
2%, 1% or skim					
Cheese					
Bread, pasta, baked goods					
Vegetarian diet					
Vegan diet					
Meat					
Luncheon meats/hot dogs					
Fruit leather/granola bars					
Roasted nuts or seeds					
Fried foods					
Water, tap					
Water, filtered					

34. Was your child breast feed? Y N If yes, how long? _____ Any problems?_____

35. If bottle-fed, what brand of formula?_____ Begun at what age? _____

36. At what age were solid foods introduced?_____

37. What were your child's first foods?_____

38. What foods does your child crave?_____

39. What foods does your child avoid?_____

40. Does your child have constant need and desire for candy and sugar?_____

41. How does your child tolerate the introduction of new foods?_____

42. Any adverse reactions like fatigue or hyperactivity after eating certain foods?_____

43. Is your child a picky eater about textures/temperatures?_____

44. Any known allergies to food?_____

45. What percentage of your food is home cooked? _____

46. How often do you eat out? _____

47. How often does your family eat dinner together? _____

48. Describe the typical atmosphere during meals? _____

49. Any other dietary concerns: _____

DIGESTION Please describe your child's stool pattern (circle appropriate descriptions):

50. Frequency of bowel movements

Less than one bowel movement/ day | One or more bowel movement/day | Diarrhea | Constipation | Alternating constipation and diarrhea

51. Stool Shape:

Separate hard lumps, hard to pass | Sausage-shaped but lumpy | Ribbon shaped | Soft blobs with clear cut edges | Mushy stool

52. Stool Color: Normal Black or tarry colored Light or clay colored Whitish pale stools

53. Stool Texture: Greasy or shiny stools Undigested food in stool Blood in stool Mucus in stool

54. Gas: None Foul-smelling stools Foul smelling gas Stomach pains Belching or gas after eating

SUGAR HANDLING

54. Yes ❒ No❒ Awaken after falling asleep, can't fall back asleep
55. Yes ❒ No❒ Crave sweets
56. Yes ❒ No❒ Binge or uncontrolled eating
57. Yes ❒ No❒ Excessive appetite
58. Yes ❒ No❒ Crave sugar in the afternoon
59. Yes ❒ No❒ Sleepy in afternoon
60. Yes ❒ No❒ Fatigue relieved by eating
61. Yes ❒ No❒ Headache if meals skipped delayed
62. Yes ❒ No❒ Irritable before meals
63. Yes ❒ No❒ Shaky if meals delayed
64. Yes ❒ No❒ Frequent thirst
65. Yes ❒ No❒ Frequent urination

ENERGY LEVEL (ADRENALS)

66. Yes ❒ No❒ Do energy levels wane during the day? If yes, what time do they get tired?_____
67. Yes ❒ No❒ Do specific foods make your child tired or bloated?
68. Yes ❒ No❒ Is your child's fatigue relieved by eating?
69. Yes ❒ No❒ Is your child a slow starter in the morning?
70. Yes ❒ No❒ Does your child tend to be keyed up, trouble calming down?
71. Yes ❒ No❒ Is your child calm on the outside, but troubled on the inside?
72. Yes ❒ No❒ Is your child chronically fatigued, or get drowsy often?

IMMUNE SYSTEM – Please check if your child experienced in his/her lifetime

84. Yes ❒ No❒ Frequent colds or flu
85. Yes ❒ No❒ Sinus infections, congestion
86. Yes ❒ No❒ Mucus producing cough
87. Yes ❒ No❒ Asthma, wheezing, difficulty breathing
88. Yes ❒ No❒ Frequent runny or drippy nose
89. Yes ❒ No❒ Bronchitis, croup, respiratory issues
90. Yes ❒ No❒ Strep throat? How often? _____
91. Yes ❒ No❒ Frequent Ear Infections
92. Yes ❒ No❒ Chicken pox
93. Yes ❒ No❒ Frequent antibiotics (more than 2x year)
94. Yes ❒ No❒ Allergies and/or hives
95. Yes ❒ No❒ Itchy skin
96. Yes ❒ No❒ Never get sick
97. Yes ❒ No❒ Dark circles under eyes

MINERAL NEEDS

100. Yes ❒ No❒ Bruises easily
101. Yes ❒ No❒ Cuts heal slowly/ scar easily
102. Yes ❒ No❒ Sunburn easily/ sun poisoning
103. Yes ❒ No❒ Frequent fevers
104. Yes ❒ No❒ Skin rashes/ dry flaky skin
105. Yes ❒ No❒ Craves salt
106. Yes ❒ No❒ Pain or swelling in joints
107. Yes ❒ No❒ Vomiting or nausea
108. Yes ❒ No❒ Nose bleeds
109. Yes ❒ No❒ Crave chocolate
110. Yes ❒ No❒ Feet have a strong odor
111. Yes ❒ No❒ Hoarseness
112. Yes ❒ No❒ Gag easily
113. Yes ❒ No❒ White spots on fingernails

SOCIAL DEVELOPMENT

114. How does your child interact with other children?_____

115. How does your child interact with adults?_____

116. What makes your child happy?_____

117. What makes your child sad?_____

118. What makes your child angry?_____

119. What makes your child stressed?_____

120. How do you as a parent deal with these emotions in your child?_____

121. How does your child do in school academically? _____

122. How does your child do in school behaviorally?_____

123. What are your child's favorite school activities? _____

124. What subjects or activities does your child struggle with? _____

125. Has your child ever harmed themselves intentionally? Harmed others?_____

BEHAVIOR/TEMPERMENT: Please place an (X) next to any issues your child may demonstrate and note details.

Description	Mild	Moderate	Severe	Unique Details
Aggression – hitting, biting, property destruction				
Anxiety -- worries, restless, scared, obsessive thoughts				
Defiance – talks back to adults, blames others, mean to peers				
Depression -- sad, irritable, hopeless, crying				
Difficulty sustaining attention, concentrating or organizing				
Difficulty handling transitions				
Excited, Hard to relax, lack of restful sleep				
Hyperactivity -- won't sit still as if "motor running"				
Irritability/tantrums				
Lethargic - no energy, sluggish				
Lack of concern or regard for others				
Low self esteem – feels like failure, sensitive to criticism				
Mood Swings -- energetic, racing thoughts, too talkative				
Poor Impulse control/ frustration tolerance				
Social anxiety --shy, afraid to be around others				

MEMORY/COORDINATION

66. Yes ❒ No❒ Is your child's mental speed slow?
67. Yes ❒ No❒ Does your child have difficulty with learning or memory?
68. Yes ❒ No❒ Does your child have difficulty with balance and coordination? slow movement?
69. Yes ❒ No❒ Does your child have difficulty with visual memory?
70. Yes ❒ No❒ Does your child have difficulty remembering locations?
71. Yes ❒ No❒ Does your child have fatigue or low endurance for learning activities?
72. Yes ❒ No❒ Does your child have slow or difficult speech?

SLEEP PATTERNS

76. Yes ❒ No❒ Does your child have difficulty falling asleep?
77. Yes ❒ No❒ Does your child sleep soundly?
78. Yes ❒ No❒ Does your child experience sleep apnea (trouble breathing while sleeping)?
79. Yes ❒ No❒ Does your child wake up often in the middle of the night? What time?_____
80. Yes ❒ No❒ Does your child's body or limbs jerk as he/she falls asleep?
81. Yes ❒ No❒ Does your child clench or grind teeth?
82. Yes ❒ No❒ Does your child have frequent nightmares?
83. Please describe early sleep history (i.e. long naps/short naps, age stopped napping)_____

_____

Is there any additional information you would like to share about your child?