A comprehensive history allows us to make the most informed clinical decisions for your child. We want to tailor our services to your child's specific needs. We have a strong interdisciplinary focus: we want to get a picture of the whole child, as we recognize that functioning in one domain is affected by factors in all domains of a child's life.

Nutrition Intake Questionnaire

A Client Information
B Medical History
C Nutrition Concerns
D Food Recall and Eating Behaviours
E Physical Activity

A Client Information

Client Name: _____
(Last) (First) (Middle Initial)

Date of Birth: _____
Age: _____
Gender: _____

Street Address: _____
City: _____
Province: _____
Postal Code: _____
P.O. Box: _____
Home Phone No.: _____
Cell Phone No.: _____

Reason for Visit: _____

Primary Language Spoken at Home: _____

Primary Language of Guardian(s): _____

Referral Name (Doctor, School, Therapist): _____

Referral Phone/Address (If known): _____

School Name: _____

Primary Care Physician Name (If different from referral): _____

Primary Care Physician Number and Address: _____

B Medical History

1. Please List Any Allergies or Intolerances Your Child Currently Has:

2. Does Your Child Have a History of Any of the Following (Circle any that apply):

- ☐ -Convulsions/Seizures
- ☐ -Head Injury
- ☐ -High Fevers
- ☐ -Bronchitis/Pneumonia
- ☐ -Sleep Problems
- ☐ -Gastroesophageal/Gastrointestinal Reflux Disorder (GERD)
- ☐ -Constipation
- ☐ -Diarrhea
- ☐ -Muscle Pain. Specify _____
- ☐ -Headaches
- ☐ -Abdominal Pain/Bloating
- ☐ -Stomach Aches
- ☐ -Asthma
- ☐ -Diabetes
- ☐ -Abnormalities of Muscle Tone
- ☐ -Shortness of Breath
- ☐ -Dizziness with Physical Exertion
- ☐ -Activity Limitation Due to Heart Condition
- ☐ -Feeding Difficulties
- ☐ -Other: _____

3. Please List Any Family History of Medical Concerns:

4. Please List Any Medications your Child is Currently Taking:

Nutrition Intake Questionnaire

C

Nutrition Concerns

1. What Are Your Child's Nutrition Goals/Concerns You Would Like to Address With Us?

2. Does Your Child Have Any Digestive Concerns? If Yes, Please Describe:

3. Does Your Child Have Any Behavioural Eating Concerns (i.e. Picky Eating)? If Yes, Please Describe:

4. Does Your Child Follow a Special Diet or Nutritional Program? If Yes, Please Specify:

5. Is There Anything Else We Should Know About Your Child's Eating Habits or Lifestyle?

D

Food Recall and Eating Behaviours

Please Tell Us a Bit About What Your Child Would Eat And Drink On a Regular Day (including estimates on portions and time eaten):

Breakfast	Snack	Lunch	Snack	Dinner	Snack

1. Where Does Your Family Usually Eat Their Meals?

2. Does Your Family Usually Eat With The Television On?

3. Does Your Child Take Vitamins or Supplements? Please Specify The Type, Dosage, and Brand:

E

Physical Activity

1. Approximately How Many Hours a Week Does Your Child Participate in Physical Activity?

2. Please List The Types of Physical Activity Your Child Participates in, Including Activities Such As Walking to School: