Nutritional Assessment Questionnaire

~ For Children

PRIVATE AND CONFIDENTIAL *(This information will not be disclosed to third parties)*

Child's first name _____ Last name _____ Date of birth _____

Address _____

_____Post code _____

Age _____Weight _____ Height _____ Ethnic origin _____

Parent/carer's name _____ Tel no_____

Mobile _____ email _____

Main reason for your visit _____

_____

_____

Your GP's name _____ Address _____

Are there any other specialists/ therapists/clinics involved in your care? _____

_____

Medications and remedies *(please list anything your child takes regularly including GP prescribed medication, non-prescribed medication (eg painkillers), nutritional supplements, herbal or homeopathic remedies)*

Remedy	Dose	Condition being treated	Frequency & duration
Antibiotic history: *(please state when and why you last took antibiotics plus any previous times you can remember)*			

Has your child had any recent health tests, surgery, diagnosed medical conditions, significant periods of ill health or suffer from any allergies, chronic or niggling health problems? *(please give details and when they occurred)*

_____

_____

_____

Heredity profile

Mother Age _____ Health problems _____

_____Are you the birth mother? _____

Father Age _____ Health problems _____

_____Are you the genetic father? _____

Siblings

Male/female _____ Age _____ Health problems _____

Male/female _____ Age _____ Health problems _____

Male/female _____ Age _____ Health problems _____

Grandparents What illnesses are/were your grandparents prone to? _____

_____

Home life

Who lives at home with your child? _____

Does your child spend time in other homes (eg grandparents, divorced parent)? _____

Does your child attend school, nursery, playgroup, child minder? _____

Are there any pets at home? _____

How much time does your child spend outdoors? _____

Does your child regularly expose his/her skin to sunlight? _____

Does your child sleep well? _____ How many hours sleep does s/he usually get? _____

What hobbies does your child have? _____

How much exercise does your child have in a week? _____

Occupation of mother _____ Occupation of father _____

Toxic exposure

Do you live near: busy roads, agricultural land, flight path, petrol station, factory, pylons (please underline)

Does your child live in a smoky atmosphere? _____

Are your child's teeth filled with mercury amalgams? _____

Does your child spend a lot of time on a TV/computer/tablet/mobile phone? _____

Does your child eat or drink from plastic containers? _____

Do you cook or wrap food in aluminium foil/cling film/plastics? _____

Does your child regularly consume artificial sweeteners? _____

Roughly what percentage of your food is organic? _____

What water does your child drink? (eg. filtered, tap, bottled in plastic, bottled in glass) _____

Pregnancy details

Previous pregnancies including any miscarriages _____

Contraceptive history _____

Was this child conceived naturally? _____

Did you suffer any illnesses during pregnancy? _____

Did you have any medical tests, scans or procedures during pregnancy and at what stage ? _____

_____

Did you travel abroad prior to or during the pregnancy? _____

Did you take any prescribed medications during pregnancy (eg antibiotics, anti-depressants, anti-nausea)? Please give details _____

Did you take any over the counter drugs, nutritional supplements or street drugs during pregnancy? Please give details _____

Did you smoke, drink alcohol or use stimulants such as coffee and cola during pregnancy? Please give details ____

_____

Was your appetite affected? Increased/decreased At what stage of pregnancy? _____

Did you lose or gain excessive weight? _____

Did you 'go off' any foods? _____

Did you crave any foods or non-foods? _____

Did you exclude any foods? _____

Any additional information about this pregnancy _____

_____

_____

Labour

Was this your first labour? _____ Did you go into labour spontaneously? _____

Medications used during labour? _____

What type of birth did your child have? (eg normal vaginal, emergency caesarean, water birth, home/hospital)

_____

Additional information about the labour _____

Did your baby require special care? Please give details _____

Did your baby suffer jaundice, oxygen deficit or any other problems? _____

Birth weight _____ Birth length _____ Birth head circumference _____

Birth centile on growth chart (eg 50th, 25th)? _____ APGAR score _____

Did you suffer from thrush or cystitis after the delivery? _____

Child's Health Profile

Has your child's growth pattern been normal? If no, please give details _____

Has your GP, Health Visitor or any other medical practitioner ever expressed concern regarding your child's development? _____

Has your child received the standard immunisations? _____

Has your child ever had an adverse reaction to any vaccine? _____

Has your child had any infectious diseases such as whooping cough, measles, chicken pox, herpes, mumps, rubella, etc ? _____

Has your child ever had antibiotics? If yes, how often _____

Has your child ever been referred to a specialist? If so, please give age, reason and type of specialist _____

_____

What tests has your child had by GP, specialist or other? _____

Has your child received a medical diagnosis of any medical condition? If yes, please give details _____

_____

Has your child ever suffered tooth decay or required dental treatment? _____

Any other medical information _____

Child's feeding history

Was your child breastfed? And for how long? _____

Did mum take any medications while breastfeeding? _____

Did your child have formula milk? And from what age? _____

How old was your baby when you started weaning onto solid foods? _____

Did your child have any reactions to foods you introduced? If yes, which foods _____

What were the first foods introduced to your baby? _____

Current diet *Please also complete the separate food and lifestyle diary*

Would you describe your child's appetite as good, medium or poor? _____

Is your child a fussy eater? _____

Which are your child's favourite foods? _____

Which foods does your child dislike? _____

Which foods does your child crave? _____

Do you think your child may be addicted to anything? _____

Do you avoid any foods for cultural/ethical reasons? _____

Is your child allergic/intolerant to any foods? _____

Do you suspect any foods don't agree with your child? _____

Please tick all that apply now and mark with a 'P' those that occurred previously

Constipation		Diarrhoea	
Tummy upsets		Bloating	
Heartburn/reflux		Excessive wind	
Bad breath		Itchy bottom	
Constant runny nose		Frequent colds/infections	
Colic		Eczema	
Asthma		Hayfever	
Dark circles under eyes		Nappy rash	
Tooth decay		Threadworms	
Earaches		Food sensitivities	
Insomnia		Poor sleep	
Night terrors		Bedwetting	
White spots on fingernails		Poor sense of taste/smell	
Slow wound healing		Nosebleeds	
Mouth ulcers		Poor night vision	
Brittle nails		Sunburn easily	
Small bumps on back of arms		Pale skin	
Dry &/or itchy eyes		Conjunctivitis	
Dry flaky skin &/or dandruff		Skin rashes or hives	
Muscle cramps/twitches		Tend to bruise easily	
Headaches		Vulnerable to insect bites	
Joint pains		Poor hair condition	
Lack of energy		Thrush	
Excessive thirst or sweating		Arthritis	
Fits/convulsions		Anxiety	
Nervous/worrier		Irritability	
Obsessive behaviour		Aggression	

Signed: _____ __ Print name: _____

Date: _____