CHILD Health Screening Questionnaire ***(to be completed by parent or guardian)***
Ages 12 and under

Date: ____ Clinician: __________________________________

Name: ____ Birth date: ________________________________

Please answer these questions to help our providers learn more about your child's nutrition and physical health.

Question	Answer
Was your child premature?	Yes / No
Is your child less than the 10th percentile on the wt/ht growth chart?	Yes / No
Is your child greater than the 90th percentile on the wt/ht growth chart?	Yes / No
Does your child have trouble sleeping?	Yes / No
Is your child on a special diet? If yes, what kind of diet? ____	Yes / No
Is your child allergic or sensitive to any foods? If yes, what foods? ____	Yes / No
Is your child a "picky eater?" If yes, how so? ____	Yes / No
(CIRCLE THOSE THAT APPLY) Does your child have any problems with diarrhea, constipation, nausea, vomiting, chewing, or swallowing?	Yes / No
During a normal week, how often is your child physical active? _____ minutes per day _____ days per week	
On a scale of 1-10, how ready are you to help your child to be more physically active? _______ *(10=extremely motivated; 1=no motivation at all)*	
Does your child have any physical health issues? ____	Yes / No
Has your child experienced unintentional weight loss or weight gain? **(IF YES, CIRCLE ONE)**	Yes / No
Does your child have concerns about their body image?	Yes / No
Are you or your child currently on WIC or other food support programs? If yes, what programs? ____	Yes / No
Does your family have enough food to eat?	Yes / No
During a normal meal, is half the food on your child's plate fruits and vegetables?	Yes / No
On a scale of 1-10, how ready are you to help your child eat more fruits and vegetables? ________ *(10=extremely motivated; 1=no motivation at all)*	
Does your child eat protein with every meal?	Yes / No
Does your child drink at least 8 glasses of water a day?	Yes / No
What concerns, if any, do you have with your child's eating habits? ____ ____	
Does anyone in your child's household smoke cigarettes?	Yes / No
On a scale of 1-10, how ready are they to quit smoking cigarettes? _______ *(10=extremely motivated; 1=no motivation at all)*	
Would you like to schedule an appointment for your child with the Dietitian? *If you answer YES to this question, a Registration staff member will contact you to schedule for nutrition services.*	Yes / No

An initial nutrition assessment is recommended to compliment the care you are already receiving here at Nystrom and Associates. Please discuss this with the Front Office Associate after your initial appointment or call (651) 529-8671 to speak with our Registration team.