Name:_____
Birth Date:_____ Today's Date:_____

Medical Nutrition Therapy Assessment
Children 12 and under

Please help us provide better care to your child by answering all questions to the best of your ability. This information will help the dietitian develop your child's nutrition treatment plan.

If you were referred to this appointment, who referred you (doctor, therapist, etc.)?
_____

Does your child see any specialty providers (allergist, gastroenterologist, etc.)? If so, please list what types:
_____

Please share how you and your child are hoping to benefit from meeting today and/or any nutrition concerns that you have (including concerns about your child's eating habits or style of parenting regarding food intake):
_____
_____
_____

Have you and your child worked with a Registered Dietitian in the past? ____Yes ____No
If yes, was it helpful? Why or why not?
_____
_____
_____

Do you have any concerns with your child's current weight, body shape, or body image?
____Yes ____No If yes, what are you or your child's concerns?

Is your child on a special diet? ___Yes ____No
If yes, what?_____

Is anyone in your household or any one in your family on a special diet: ___Yes __No
If yes, what?_____

Weight Loss/Gain

What is your child's most recent weight?_____
What is your child's most recent height?_____

Describe your child's growth pattern (underweight, overweight, normal development):_____
_____
_____

Has it been consistent (ex-following the same percentiles for height and weight)?
_____Yes_____No Explain your answer_____
_____
_____

Health History

Please check any health concerns, add in any additional pertinent information:

Lungs or Breathing:
- ☐ Asthma
- ☐ Bronchitis
- ☐ Other_____

Cardiovascular:
- ☐ High cholesterol
- ☐ High blood pressure

Endocrine:
- ☐ Thyroid problems
- ☐ Diabetes

Autoimmune:
- ☐ Celiac Disease
- ☐ Lupus

Other:
- ☐ Anemia
- ☐ Liver disease
- ☐ Kidney disease
- ☐ Substance abuse
- ☐ Difficulty chewing
- ☐ Difficulty swallowing

Mental Health Problems
- ☐ Depression
- ☐ Anxiety
- ☐ _____

Gastrointestinal:
- ☐ Abdominal pain
- ☐ Cramping
- ☐ Gas
- ☐ Bloating
- ☐ Constipation
- ☐ Diarrhea
- ☐ Non-celiac gluten sensitivity
- ☐ IBS
- ☐ Blood in the stool
- ☐ GERD
- ☐ Nausea/Vomiting

Developmental/Behavioral
- ☐ ADHD/ADD
- ☐ Fetal Alcohol Spectrum Disorder
- ☐ Autism Spectrum Disorder
- ☐ Trouble concentrating

Skin:
- ☐ Dermatitis herpetiformis
- ☐ Other:_____

Other
- ☐ _____
- ☐ _____
- ☐ _____

Allergies/Intolerances

What allergies, sensitivities, and intolerances (to drugs, food, latex, environmental) or adverse reactions has your child experienced?

Allergic or intolerant to:	Reaction time: (eg-immediate, slow, etc)	Type of reaction or problem:

Does your child drink cow's milk and/or eat dairy products? ___Yes ___No
If no, why not?_____

Has your child been previously tested for any food allergies or sensitivities? ____Yes ____No
If yes, please explain:
_____
_____
_____

Sleeping Patterns

What time does your child usually wake up?_____

What time does your child usually go to bed?_____

Average hours of sleep per night? _____

Average hours of sleep (ie napping) during the day?_____/ NA

Does your child have a snack before bed? ___Yes ___No
If yes, describe_____
_____

If waking up in the middle of the night, does your child need a snack to get back to sleep?
____Yes _____No. If Yes, please explain:_____
_____

Any comments or history regarding your child's sleeping patterns (ex: sleeping with a bottle, current medications or supplements, nightmares, etc):_____

Exercise Patterns and Attitudes

Is your child physically active: ____Yes ____No
If yes, please describe what activities they enjoy:_____
_____

Is your child involved in any sports? ___Yes ___No
If yes, what does your child do? How often does he/she practice and for how long?_____
_____

How many hours does your child usually spend on television, video games and/or computers per day during the Week?_____ The Weekend_____ Comments_____
_____

Medications and Supplements

List all medications that your child is currently taking.

- ☐ My child is not currently taking any medications

Medication	Reason for Use	Negative side effects experienced

List all supplements your child is currently taking.

- ☐ My child is not currently taking any supplements

Supplement	Reason for use	Dose and times per day

Eating Patterns

Does your child attend: ____Daycare____Preschool____Elementary School____Middle School

What meals and/or snacks are provided to your child while attending any of the above?_____
_____
Within your child's household, who does most of the cooking?_____
_____

Within your child's household, who does most of the grocery shopping?_____

Does your family eat meals together? ___Yes ___No Which meals?_____
_____

Does your child have structured sit-down snack times? ____Yes ____No
If yes, what are the snack times and what foods are offered?_____
_____

How would you describe your child's appetite? _____Excessive _____Normal_____ Fair____Poor
Comments:_____
_____

Describe your child's behavior at meal time:_____
_____

Who portions the food? _____

Is your child a picky eater? __Yes __No
If yes, please describe:_____
_____
_____

Is your child currently experiencing any feeding problems or issues? ___Yes ___No
If yes, please describe:_____
_____

Any texture issues with food? ___Yes ___No
If yes, please describe:_____
_____

How many times per week does your child eat at restaurants or get take out? _____
What restaurants?_____
_____

Do you or your child have a concern with any of the following (check all that apply)?

- ☐ Binge eating
- ☐ Purging
- ☐ Restrictive eating
- ☐ Overeating
- ☐ Night eating
- ☐ Body image
- ☐ Excessive exercise
- ☐ Other_____

Please explain:_____
_____
_____

Does your child drink fruit juice, soda, or energy drinks? ___Yes ___No
If yes, what kinds and how much on a daily basis?
_____
_____
_____

Diet Recall: To the best of your ability, please write down your child's food and beverage intake from yesterday (include meals, snacks, beverages, portions, and times):

Would you consider this a typical day? ____Yes ____No If no, why not?

_____

_____

Motivation

On a scale of 1-10, (10=extremely motivated; 1= no motivation at all), how would you rate YOUR CHILD'S current motivation to make nutrition and lifestyle changes:_____

What might make it difficult for your child to make changes?

_____

_____

_____

On a scale of 1-10, (10=extremely motivated; 1= no motivation at all) as the parent/guardian, how would you rate YOUR current motivation to help your child make nutrition and lifestyle changes?

_____

What might make it difficult for you or other family members to make changes?

_____

_____

_____

Who is involved in your child's life that would support them in making changes?

_____

_____