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?

<table>
<thead>
<tr>
<th>Allergic or intolerant to:</th>
<th>Reaction time: (eg-immediate, slow, etc)</th>
<th>Type of reaction or problem:</th>
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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

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<tr>
<th>Medication</th>
<th>Reason for Use</th>
<th>Negative side effects experienced</th>
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List all supplements your child is currently taking.

☐ My child is not currently taking any supplements

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<tr>
<th>Supplement</th>
<th>Reason for use</th>
<th>Dose and times per day</th>
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**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?

_____________________________________________________________________________________

_____________________________________________________________________________________

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