Nutritional History Parent Questionnaire-New Patients/Families

Before we can see your child for a nutritional consultation, we need you to answer the following questions about your child and family.

Child's Name ____ **Birth date** ___________________

Name of School ____ **Grade** ______________________

Do you know your child's current weight? ________________ Height? _________________

What was your child's highest weight? ______________ How long ago? ________________

What was your child's lowest weight? _______________ How long ago? ________________

Are you concerned about your child's weight? ______________________________________

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____

What changes have you noticed in your child's eating habits? ______________________

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Is your child a vegetarian? ______ If yes, what won't he/she eat? _________________

____

Is there a family history of eating disorders? __________ If yes, who and what problem?____

____

Is there a family history of depression, anxiety, substance abuse or other psychiatric illness? _______ If yes, who and what type? ___________________________

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Has your child been diagnosed with depression, anxiety obsessive compulsive disorder or other psychiatric illness? _________ If yes, what type of treatment did they receive? ____

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Has your child ever been physically or sexually abused? _______ If yes, when and how? ____

____

Is your child currently working with a counselor? ______ If yes, who and through which office or program? ____

Is your child currently working with a dietician? ______ If yes, who and through which office or program? ____

Has your child ever been admitted to the hospital or a residential treatment facility for their eating disorder? _______ If yes, where, when and for how long?

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____

Is your child currently taking any medications? _______ If yes, please list.

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Is there a family history of obesity, diabetes or heart disease?_____ If yes, in whom and when was it diagnosed? ____

____

What extra-curricular activities does your child participate in? __________________

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____

How does your child exercise? ____

____

____

Are you concerned that your child is vomiting after they eat? _______ If yes, why?

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Has your child ever been admitted to the hospital or had previous surgeries? ______ If yes, please list when and for what reason:___________________________________

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Describe your family's living arrangements: ____
____
____

Have there been any stressors in your home? ____
____
____

Is your child experiencing any stressors at school or with peers? _________________
____
____

How does your child do in school? Has there been any change in his/her level of academic performance? ____
____
____

Does your child bring their lunch to school or do they eat hot lunch from the cafeteria? ____

What are your family's attitudes regarding weight? Has anyone in your family struggled with their weight? ____
____
____

How do the adult members of your family maintain a healthy weight? ________________
____
____
____
____

Is there pressure to diet in your family? Are any family members currently on a diet? ____
____
____
____

Describe a typical day, in detail, of what and how your child eats and drinks.

Meal	Quantity and type of food	Behaviors during meal and where they eat it
Breakfast		
Snack		
Lunch		
Snack		
Dinner		
Snack		