Phone (631) 374-6371
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NUTRITION QUESTIONNAIRE

Date: _____
Completed by: _____

PATIENT INFORMATION:
Name: _____ **Sex:** _____

Date of Birth: _____ **Age:** _____ **years,** _____ **months**

Diagnosis: _____

ANTHROPOMETRICS

Weight: _____ **Height:** _____ **Date of measurement:** _____

Do you have any concerns regarding your child's growth? _____ NO _____ YES
If yes, _____
Please attach a copy of your child's growth charts if available.

BIOCHEMICAL

List any blood, urine, or stool laboratory tests your child completed within the past year:
If available, please attach a copy of lab tests results.

List any medical or gastrointestinal diagnostic tests your child has ever had completed.
If available, please attach a copy of diagnostic tests results:

CLINICAL

Primary Diagnosis: _____

Other Medical Conditions: _____ NO _____ YES
If yes, _____

Has your child had any surgeries? _____ NO _____ YES
If yes, _____

Does your child have more than 5 acute illnesses per year? _____ NO _____ YES
If yes, _____

Does your child have low muscle tone? _____ NO _____ YES
If yes, _____

Is your child diagnosed with Sensory Processing Disorder? _____ NO _____ YES
If yes, _____

Does your child take any prescribed medication? _____ NO _____YES
If yes, _____

Does your child have delayed expressive language? _____ NO _____ YES
Does your child have delayed receptive language? _____ NO _____ YES

Does your child have problems with Sleep?
- Difficulty falling asleep: _____ NO _____ YES
- Difficulty with staying asleep all night: _____ NO _____ YES

If yes, _____

Has your child had a dental exam within the last year? _____ NO _____ YES

Is your child diagnosed with a Gastrointestinal Disorder? _____ NO _____ YES
If yes, _____

Has your child had any gastrointestinal diagnostic test? _____ NO _____ YES
If yes, list test and results: _____

Does your child have any of the following gastrointestinal symptoms?

- Undigested food in stool _____ NO _____ YES
- Bloated stomach _____ NO _____ YES
- Stomach pain _____ NO _____ YES
- Excess gas _____ NO _____ YES
- Constipation _____ NO _____ YES
- Diarrhea _____ NO _____ YES
- Loose stools _____ NO _____ YES
- Foul smelling stools _____ NO _____ YES
- Rarely or never has normal stools _____ NO _____ YES

The average <u>number</u> of bowel movements your child has per day? _____

What is the <u>consistency</u> of your child's stool on a typical day? _____

Has your child been diagnosed with Food Allergies? _____ NO _____ YES
If yes, _____

Do you suspect your child has a Food Allergy? _____ NO _____ YES
If yes, _____

Has your child had food allergy testing? _____ NO _____ YES
If yes: Positive reactions: _____

Does the child's parents are siblings have any food allergies? _____ NO _____ YES
If yes, _____

Does your child have any of the following food allergy symptoms?

- Reflux as an infant _____ NO _____ YES
- Colic as an infant _____ NO _____ YES
- Reflux _____ NO _____ YES
- Vomiting _____ NO _____ YES
- Ear infections _____ NO _____ YES
- Runny nose _____ NO _____ YES

- Sneezing _____ NO _____ YES
- Wheezing _____ NO _____ YES
- Asthma _____ NO _____ YES
- Eczema _____ NO _____ YES
- Hives _____ NO _____ YES
- Skin rash _____ NO _____ YES
- Dark circles under eyes _____ NO _____ YES
- Headaches _____ NO _____ YES
- Gastrointestinal (diarrhea, constipation, etc…) _____ NO _____ YES

If yes, _____

If your child has food allergies, how are they being treated?_____

Has your child been diagnosed with any Airborne Allergies? _____ NO _____ YES
If yes, _____

If your child has Airborne allergies, how are they being treated?_____

DIETARY

Have you tried any of the following diets with your child?

DIETS	**NO** (did not try)	**YES** (helped)	**YES** (made worse)	**YES** (not sure)
Gluten Free Casein Free				
Specific Carbohydrate Diet™ (SCD™)				
Antifungal (yeast-free)				
Feingold				
Low Oxalate				
No Phenol				
Food Elimination/Challenge				
Other:				
Other:				
Other:				

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Do you have difficulty buying foods for your child's elimination diet? _____ NO _____ YES
If yes, _____

Please answer the following questions regarding your child's diet:

Bread, Cereal, Rice & Pasta Group:

Is your child on a Gluten Free Diet? _____ NO _____ YES

What type of bread does your child eat: _____ White _____ Whole Wheat
_____ Gluten Free

Which types of flours do you cook with: _____

How often does your child eat?	DAILY	WEEKLY	SELDOM	NEVER
Breads	_____	_____	_____	_____
Hot cereal	_____	_____	_____	_____
Cold, dry cereal	_____	_____	_____	_____
Brown Rice	_____	_____	_____	_____
Pasta	_____	_____	_____	_____

Milk, Yogurt, Cheese and/or Alternatives Group:

Is your child on a Casein Free Diet? _____ NO _____ YES

Which type of milk does your child drink: _____ Whole _____ Low fat _____ Skim
_____ Soy _____ Rice _____ Almond
_____ Coconut _____ Goat _____ Other

How often does your child eat?	DAILY	WEEKLY	SELDOM	NEVER
Milk	_____	_____	_____	_____
Yogurt	_____	_____	_____	_____
Cheese	_____	_____	_____	_____
Juice (fortified with calcium)	_____	_____	_____	_____

Fruits & Vegetables Group:

Does your child eat at least 5 servings of fruits & veggies daily?	_____ NO	_____ YES
Does your child eat a citrus fruit or dark green leafy veggie daily?	_____ NO	_____ YES
Do you wash your fresh produce with a "veggie wash"?	_____ NO	_____ YES
Do you purchase organic grown produce?	_____ NO	_____ YES

Fiber:

How often does your child eat?	DAILY	WEEKLY	SELDOM	NEVER
Fresh fruits and vegetables	_____	_____	_____	_____
Whole grains	_____	_____	_____	_____
Dried beans and peas	_____	_____	_____	_____

Meat, Poultry, Fish, Dry Beans, Eggs, Nuts and/or Alternatives Group:

How often does your child eat?	DAILY	WEEKLY	SELDOM	NEVER
Red meats	_____	_____	_____	_____
Pork	_____	_____	_____	_____
Veal or Lamb	_____	_____	_____	_____
Poultry	_____	_____	_____	_____
Fish	_____	_____	_____	_____
Dry Beans and Peas	_____	_____	_____	_____
Eggs	_____	_____	_____	_____
Nuts and/or Seeds	_____	_____	_____	_____
Tofu, Soy, and/or Soybeans	_____	_____	_____	_____
Peanut Butter	_____	_____	_____	_____

Fats & Oils:

Which types of liquid oils do you use? _____Canola _____ Olive _____ Soybean
_____ Corn _____ Other

Does your child consume? _____ Butter _____ Margarine _____ Nut butters
Do you cook with solid fats such as Crisco or Lard? _____ NO _____ YES
Do you use flaxseed for cooking or in food preparation? _____ NO _____ YES

Water:

How many cups of water does your child drink daily? _____

What type of water does your child drink? _____ Tap
_____ Bottled (Brand: _____)
_____ Filtered (Type of filter: _____)

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Sugar:

Which type of sugar does your child consume?

_____ Table sugar _____Brown sugar _____ Honey _____ Fructose _____ Stevia
_____ Artificial sweeteners _____Other

How often does your child eat/drink?	DAILY	WEEKLY	SELDOM	NEVER
Candy	_____	_____	_____	_____
Sweets (cookies, cake, pie, etc…)	_____	_____	_____	_____
Cola, and soft drinks	_____	_____	_____	_____
Kool-aid	_____	_____	_____	_____
Fruit punch	_____	_____	_____	_____
Gatorade or sports drinks	_____	_____	_____	_____

Are you concerned about your child's diet? _____ NO _____ YES

If yes, _____

List the vitamin, mineral, herbs, and other nutritional supplements your child is currently taking:

SUPPLEMENT	PRODUCT NAME	DOSAGE	COMMENTS

***Please attach a copy of the bottle's ingredient label.**

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ENVIRONMENTAL

Any family cultural food patterns that restrict your child's diet? _____ NO _____ YES
If yes, _____

Does your child sit-down at the table for meals and snacks? _____ NO _____ YES
If no, _____

Does your child sit-down with the family to eat meals? _____ NO _____ YES
If no, _____

Does your child "graze" on food throughout the day? _____ NO _____ YES
If yes, _____

Are there distractions during meal-time such as T.V.? _____ NO _____ YES
If yes, _____

FEEDING

Does your child have a history of any of the following?

Reflux:	_____ NO	_____ YES
Problems with breast-feeding:	_____ NO	_____ YES
Problems with bottle feedings:	_____ NO	_____ YES
Difficulty transitioning from baby food to table foods:	_____ NO	_____ YES
Fed a special formula as an infant:	_____ NO	_____ YES

If yes, _____

Does your child eat a limited variety of foods (< 20 foods)? _____ NO _____ YES
If yes, _____

Does your child tantrum when presented with new foods? _____ NO _____ YES
If yes, _____

Has your child discontinued eating foods he/she used to eat? _____ NO _____ YES
If yes, _____

Does your child have any rituals at meal-time? _____ NO _____ YES
If yes, _____

Does your child refuse foods of a certain texture? _____ NO _____ YES
If yes, _____

Does your child need assistance to feed him/her self? _____ NO _____ YES
If yes, _____

Does your child use age appropriate feeding/drinking utensils? _____ NO _____ YES
If no, _____

Does your child have trouble chewing or swallowing? _____ NO _____ YES
If yes, _____

Does your child express hunger? _____ NO _____ YES
If no, _____

Does your child have a good appetite? _____ NO _____ YES
If no, _____

Is food or candy ever used as a reward? _____ NO _____ YES
If yes, _____

Has your child ever received Feeding Therapy? _____ NO _____ YES
If yes,
_____

Are you concerned that your child has a feeding problem? _____ NO _____ YES
If yes, _____

MISC

Has your child seen a Registered Dietitian in the past? _____ NO _____ YES
If yes, _____

Is your child receiving biomedical treatment from a DAN Physician? _____ NO _____ YES
If yes, _____

List the current therapies your child is receiving:

_____
_____
_____
_____
_____

Does your child have a therapy plan? _____ NO _____ YES
If yes: _____ IFSP
_____ IEP
_____ Other (_____)

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List the 3 major concerns regarding your child you would like me to help you with:

1. _____
2. _____
3. _____

Please provide any other information you would like me to know about your child:

_____

_____

_____

_____

_____

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3-Day Food Record

Instructions:
Write down all food and beverages your child eats or drinks for 3 days. Please keep your child's usual meal and snack routine.

The following directions will guide you in filling out the food record correctly.

- Please record the date and time of day the food or beverage is consumed. Record the actual amount child consumes, not amounts offered.
- Include an exact description of the food/beverage and amount consumed. Include condiments, dressings, sauces, etc…
- Use measuring spoons and cups when possible when serving your child for these three days to report the amounts consumed more accurately.
- Include any foods or candy that is used as a reward or in therapy sessions.
- Include any helpful notes, such as if your child was sick, not a typical day, or a typical day, etc…

An example is provided for you:

DATE	TIME	FOOD & BEVERAGES	AMOUNT	COMMENTS
Jan 10, 2011 (Monday)	7:00am	Apple juice	12 ounces	Breakfast at home
		Pancake (box mix)	2 bites (⅛ pancake)	Refused to eat
		Maple syrup	1 teaspoon	
		Butter	½ teaspoon	
	10:00am	Pringles chips	10 each	Used as a reward
	10:30am	Water	few sips	
	11:30am	Chicken nuggets (frozen)	3 each	Lunch at school
		Catsup	2 tablespoons	
		Mac & Cheese	½ cup	
		Chocolate Milk	1 cup	
	1:00pm	M & M candy	15 each	Used as a reward
	2:15pm	M & M candy	10 each	
	3:00pm	Hi-C fruit punch	8 ounces	Snack after school
		Chocolate chip cookie	2 (medium size)	
	6:00pm	McDonald's French fries	20 each	

		Catsup	3 tablespoons	
		Hamburger bread	½ bun	Refused to eat the meat patty
		Coke	16 ounces	
	7:30pm	Goldfish crackers	10 each	
	8:00pm	Milk (whole)	1 cup	Prior to bedtime

Notes: Typical day. John refused to eat breakfast, only wanted to drink juice. Chips and candy used as a reward in therapy. He refused to eat the meal I prepared family for dinner; he had a tantrum so we took him to McDonald's.

Child's Name: _____ **Day 1**

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3-Day Food Record

DATE	TIME	FOOD & BEVERAGES	AMOUNT	COMMENTS

Notes:

_____

_____

_____

_____

Child's Name: _____ **Day 2**

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3-Day Food Record

DATE	TIME	FOOD & BEVERAGES	AMOUNT	COMMENTS

Notes:

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Child's Name: _____ **Day 3**

3-Day Food Record

DATE	TIME	FOOD & BEVERAGES	AMOUNT	COMMENTS

Notes: