Name: ______________________________ Date of Birth: __________

Email Address: ____

Preferred method of contact: Email Phone: ________________

Patient/Parent signature:__________________________ Date:________

DuPage Medical Group

WE CARE FOR YOU

PEDIATRIC Nutrition Assessment form

General Information

Ethnicity:

Caucasian African American Hispanic Native American Asian Middle Eastern

Language preference: English Other ____________________________

Education: What school do you attend?______________________________ Grade?________________

Employment: Do you have a job? YES NO

If yes, what do you do?______________________________ What are your typical work hours?________________

Learning Style: Are there any things we should know about that would interfere with your ability to learn?

None Hearing Visual Reading Language Psychological Other - ________________________

How do you learn best? Reading Doing Observing/Listening Classes Films Computer

Cultural / Religious Beliefs:

Do you have any cultural / religious practices or beliefs that influence your diet?

No Yes If yes, please describe____

Mothers name: ______________________________ **Father's name:** ______________________________

Divorced parents: Who does the child spend most time with? Mother Father Specify:__________________________

Medical History

Family medical issues:	Dad	Mom	Other	Family medical issues:	Dad	Mom	Other
Cancer				High blood pressure			
Depression				High cholesterol			
Diabetes							
Gastrointestinal problems							
Heart Attack / Stroke							

Medical Diagnosis / Reason for this visit:____

Dental – date of last exam: (month/year)______________ **Medication Allergies:** Yes No List:________________

Hospitalizations: How many times have you been hospitalized? ________________________

Reason(s)____

Emergency Room: How many times have you been to the ER? ________________________

Reason(s)____

Prescription Medications:	**Record the information as it is written on your medication containers**				
Name	**Dose**	**What is it for?**	**Start Date**	**Amount Taken**	**When Taken**
(example)Singulair	*4 mg*	*Asthma*	*3/5/03*	*1 tablet*	*At bedtime*

Nonprescription Medications:							
	Yes	No	Comment:		Yes	No	Comment:
Allergy meds				Laxatives			
Cough/Cold meds				Diet pills			
Aspirin/Pain relief				Vitamins/Mineral			
Antacids				Other:			

Lifestyle Assessment

Activity

Do you have PE/Gym at school? YES NO If yes, at what time?_________________

Do you get activity / play sports on a regular basis? YES NO

How much activity do you do per day? None 1-30 min 30-60 min 60+ min

What type of activity / sports do you do?____

Are there any medical reasons that limit / stop (circle one) you from daily activity? YES NO Explain:_______________

How much time is spent each day sitting in front of a television or computer? None < 1 hr 1-2 hr 2+ hrs

Miscellaneous

Within the last year, how many days of school / work have you missed? ______________________________________

How would you rate your stress level? Low Moderate High

During the past month, have you often been bothered by feeling down, depressed, or hopeless? YES NO

During the past month, have you often been bothered by little interest or pleasure in doing things? YES NO

What time do you wake up?___________ What time do you go to sleep?____________ Nap time(s)?__________________

Day Care? YES NO Other caregivers:____

Nutrition Assessment

Height: ________ **ft** ________**inches** **Current Weight:**______________ **Desired Weight:**__________________

In the past month have you: Lost Weight Gained Weight # lbs lost/gained:__________ No Change

If you lost weight was it: Intentional Unintentional

Do you have any diet restrictions? (include food allergies and intolerances) ____

____

Give a sample of your meals for a typical day (If you brought in a food log, give it to the dietitian and go to the next question)

Time: ____________ Breakfast: ____

Time: ____________ Snack: ____

Time: ____________ Lunch: ____

Time: ____________ Snack: ____

Time: ____________ Dinner: ____

Time: ____________ Snack: ____

Is it hard to control what you eat? YES NO

How many times do you eat out (do not include any meals brought from home to school/work)**?** 0-1 2-4 5-8 Daily

Type of restaurants: Fast food / Take out Buffet Cafeteria / Formal restaurant

Type of foods ordered when eating out: ____

Do you skip meals? No Sometimes Yes If yes, how often? ______ times per week

How often do you eat the following foods?

Fruit	daily/often	occasionally	rarely	never		
Fruit Juice	daily/often	occasionally	rarely	never		
Vegetables	daily/often	occasionally	rarely	never		
Red Meat	daily/often	occasionally	rarely	never		
Fish	daily/often	occasionally	rarely	never		
Fried foods	daily/often	occasionally	rarely	never		
Milk	daily/often	occasionally	rarely	never	**Kind?**	Skim 1% 2% Whole
Soda	daily/often	occasionally	rarely	never	**Kind?**	Regular Diet

How many 8 oz glasses of water do you drink daily? 0-1 2-4 5-8 9+

Do you drink alcohol? NO YES If yes, what type? __________ Amount ________ per day/week (circle one)

Do you use tobacco? NO YES If yes, what type? __________ Amount ________ per day/week (circle one)

Assessment reviewed by: ____RD Date: ________________________