



ANN C. GERBER, RD, LD

## Pediatric Patient Information

### Parents:

*Please complete the information below, print a copy for your records, and then fax or email it in at least two days prior to your initial visit.*

### General Information:

Child's Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Parents'/Care Givers' Name(s): \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Phone #2: \_\_\_\_\_ Email: \_\_\_\_\_

Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Gender: \_\_\_\_\_

Reason for Appointment: \_\_\_\_\_

Primary Care Provider: \_\_\_\_\_

Address/Phone: \_\_\_\_\_

Therapist: \_\_\_\_\_

Address/Phone: \_\_\_\_\_

Referred by: \_\_\_\_\_

Grade in School: \_\_\_\_\_ Name of School: \_\_\_\_\_

Parent's Marital Status:  Single  Married  Divorced  Separated  Widowed

Parent's Occupation(s): \_\_\_\_\_

Siblings: Brother(s): \_\_\_\_\_ Ages: \_\_\_\_\_ Sister(s): \_\_\_\_\_ Ages: \_\_\_\_\_

### Medical History:

Height: \_\_\_\_\_ Current Weight: \_\_\_\_\_

Growth History: \_\_\_\_\_

Are you concerned with your child's weight?  Yes  No

Mother's Height: \_\_\_\_\_ Father's Height: \_\_\_\_\_

Are you concerned with your own weight?  Yes  No

Birth Weight: \_\_\_\_\_ Breast fed? \_\_\_\_\_ How long? \_\_\_\_\_

Bottle fed? \_\_\_\_\_ How long? \_\_\_\_\_ Formula: \_\_\_\_\_

Early feeding problems: \_\_\_\_\_  
 At what age were foods first introduced? \_\_\_\_\_  
 List complications: \_\_\_\_\_

Food allergies/intolerances as an infant/toddler?  Yes  No

Please specify: \_\_\_\_\_

Symptoms: \_\_\_\_\_

Normal Pregnancy?  Yes  No List complications: \_\_\_\_\_

Normal Delivery?  Yes  No List complications: \_\_\_\_\_

Normal Growth/Development?  Yes  No List complications: \_\_\_\_\_

***Please indicate whether your child or a family member have/had any of the following conditions:***

Disease/Condition	Child	Family	Relationship	Treatment
Asthma	_____	_____	_____	_____
Cancer	_____	_____	_____	_____
Cardiovascular Disease	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____
Drug Dependency	_____	_____	_____	_____
Eating Disorder	_____	_____	_____	_____
Food Allergies	_____	_____	_____	_____
Food Intolerances	_____	_____	_____	_____
Kidney Disease	_____	_____	_____	_____
Headaches	_____	_____	_____	_____
Heart Attack	_____	_____	_____	_____
High Cholesterol	_____	_____	_____	_____
Hypertension	_____	_____	_____	_____
Intestinal Problems	_____	_____	_____	_____
Menstrual Problems	_____	_____	_____	_____
Mental Health Issues	_____	_____	_____	_____
Obesity	_____	_____	_____	_____
Osteoporosis	_____	_____	_____	_____
Other	_____	_____	_____	_____

List any medications your child is taking or has taken in the last year: \_\_\_\_\_

Is your child currently taking any food supplements, vitamin, mineral, or herbal supplements?  Yes  No

If yes, please specify: \_\_\_\_\_

**Menstrual History:** (Female Patient):

Age began menstruating: \_\_\_\_\_ years of age  Have never menstruated

Date of last menstrual cycle: \_\_\_\_\_ Weight at that time: \_\_\_\_\_ pounds

**Dieting History:**

Has your child ever dieted? \_\_\_ Yes \_\_\_ No How many diets has your child been on? \_\_\_\_\_

Age of first diet: \_\_\_ Years Weight at that time: \_\_\_ pounds

Why did your child go on the diet? \_\_\_\_\_

**Exercise History:**

Does your child currently exercise/participate in sports? \_\_\_ Yes \_\_\_ No

Type, duration, frequency, and intensity of exercise activities: \_\_\_\_\_

What types of physical activities does your child enjoy? \_\_\_\_\_

**Eating Habits:**

How many days per week does your child eat:

Breakfast: \_\_\_\_\_ Lunch: \_\_\_\_\_ Dinner: \_\_\_\_\_ Snacks: \_\_\_\_\_

When does your child usually snack? \_\_\_\_\_

Does your child eat out (restaurants, take-out, fast food, etc.)? \_\_\_ Yes \_\_\_ No

How often? \_\_\_\_\_

List restaurants usually chosen: \_\_\_\_\_

Does your child take lunch to school or buy lunch at school? \_\_\_\_\_

Examples of food choices: \_\_\_\_\_

Does your child eat snacks at school? \_\_\_ Yes \_\_\_ No What? \_\_\_\_\_

Who is responsible for grocery shopping? \_\_\_\_\_

Who prepares/cooks the meals? \_\_\_\_\_

Do you read food labels? \_\_\_ Yes \_\_\_ No What do you look at on the label? \_\_\_\_\_

Does your child eat standing up, walking, etc.? \_\_\_ Yes \_\_\_ No

Does your child eat in the car, on the bus, etc.? \_\_\_ Yes \_\_\_ No

Does your child eat in front of the TV? \_\_\_ Yes \_\_\_ No

Does your child eat while reading, on the computer, etc.? \_\_\_ Yes \_\_\_ No

Does your child eat with others? \_\_\_ Yes \_\_\_ No

Does your child eat faster/slower than others? \_\_\_ Yes \_\_\_ No

Does your child eat when stressed/bored/lonely? \_\_\_ Yes \_\_\_ No

Does your child feel bad after eating? \_\_\_ Yes \_\_\_ No

Does your child sneak food/hide food? \_\_\_ Yes \_\_\_ No

Does your child wish others wouldn't comment on what he/she ate? \_\_\_ Yes \_\_\_ No

Does your child feel like he/she eats differently than others? \_\_\_ Yes \_\_\_ No

Describe: \_\_\_\_\_

Does your child know what hunger & fullness feel like?  Yes  No

Does your child prepare his/her own meals?  Yes  No

Does your child avoid certain foods?  Yes  No

Please specify: \_\_\_\_\_

What are your child's favorite foods? \_\_\_\_\_

What food does your child dislike? \_\_\_\_\_

Please list your main concerns about your child's nutritional intake: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Family Weight History:**

Are any members of your family overweight?  Yes  No Explain: \_\_\_\_\_

Are any members of your family underweight?  Yes  No Explain: \_\_\_\_\_

Does anyone in your family diet?  Yes  No Explain: \_\_\_\_\_

Did/Does anyone in your family have an eating disorder?  Yes  No

Explain: \_\_\_\_\_

Does your family eat meals together?  Yes  No Which meals? \_\_\_\_\_

**Goals/Expectations:**

Do you want to change your child's nutritional habits?  Yes  No

Why? \_\_\_\_\_

Did you have any expectations from coming to see the nutritionist today?  Yes  No

Please explain: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Food Frequency Checklist

Patient's Name: \_\_\_\_\_ Date: \_\_\_\_\_

Show portion sizes or simply check how often the following foods are consumed	Never or Less than Once per Week	1-2 Times per Week	3-7 Times per Week	More than Once a Day
Beef				
Sausage, Bacon, Lunchmeat				
Pork				
Poultry				
Poultry – Prebreaded, e.g. nuggets				
Poultry – Fried				
Fish				
Fish – Prebreaded, e.g. fish sticks				
Fish – Fried				
Shellfish				
Beans				
Peanut Butter				
Pizza				
Milk (Specify Type)				
Cream				
Cheese				
Cheese – Regular				
Cheese – Low Fat				
Cheese – Non-Fat				
Yogurt				
Ice Cream				
Frozen Yogurt				
Eggs				
Oils				
Butter				
Margarine				
Vegetables				
Fruits				
Fruit Juice				



## Instructions for Completing the Food and Activity Diary

1. Write down everything you eat or drink and activity you perform for at least three recent days (two weekdays and one weekend). Remember to include snacks and "tastes" between meals as well as "extra" activities such as walking between floors.
2. Keep track of the amounts of food served in common portion sizes such as cups, tablespoons or describe size (e.g. 1 large banana -- 8" long).
3. Indicate how the food was prepared: fried, steamed, baked, raw.
4. Be as specific as possible. Instead of "Turkey sandwich," say, "Turkey sandwich made with 2 slices of Wonder Light whole wheat bread, 4 slices of Sara Lee deli select turkey breast, 1 tablespoon Hellman's reduced fat mayonnaise, and two 4-inch pieces of romaine lettuce.
5. List brand names of all food products, for example, oatmeal might be "Quick Quaker Oats."
6. Be sure to measure and record all those little extras: gravies, salad dressings, taco sauce, pickles, jelly, sugar, ketchup, margarine, etc. Indicate the amounts.
7. Attach recipes for any unusual items you prepare at home.
8. For activities, describe the activity type and intensity (e.g. "walked up three floors," "treadmill (450 cal)," "ran on HS track (3.5 mi)").











Wellness On The Run

**ANN C. GERBER, RD, LD**

## **Office Policy Information**

### **Payment:**

Payment is expected at the time of your appointment. Checks are to be made payable to Wellness on the Run. If there is any difficulty in making payment at the time of the visit, please confirm alternate arrangements at the time of the initial interview.

### **Cancellation Policy:**

Individual appointments are scheduled for a specific time. You will be charged for missed individual appointments unless the R.D. is notified of cancellation at least 24 hours in advance, or in cases of emergency.

### **Confidentiality:**

All information disclosed within sessions is confidential as outlined in the Notice of Privacy Practices.

### **Medical Insurance:**

Medical insurance companies may or may not offer coverage for medical nutrition therapy. Carefully investigate the type of coverage you have. It is your responsibility to pay for your visit and to have your insurance company reimburse you if applicable. You will be provided with a receipt that you can submit to your insurance company for reimbursement.

I have read and understand the above information.

Signature of responsible party: \_\_\_\_\_

Date: \_\_\_\_\_