Print

NOTE:

To avoid having to re-enter information on this form, please use the Print button as soon as you are finished. Certain versions of Adobe will not allow you to save your work.

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				

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
Breads				
Cereals				
Pasta, Noodles, Rice, Etc. (cup)				
Potatoes				
Commercial Baked Goods (cookies, donuts, cakes, etc.) (Serving)				
Cookies				
Soft Drinks (Non-Diet) (Serving)				
Snack Crackers (Serving)				
Nuts and Seeds (1/4 Cup)				
Potato Chips or Corn Chips (Cup)				
Sherbets and Ices (1/2 Cup)				
Candy				
Frozen Meals				
Chinese Food				
Fast Food				

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 feed 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)").

Food and Activity Diary

Name: _____ Ending Date / /

Time and Place	Foods Eaten	Duration (min)	Activity Performed	Duration (min)

Food and Activity Diary

Name: _____ Ending Date / /

Time and Place	Foods Eaten	Duration (min)	Activity Performed	Duration (min)

Food and Activity Diary

Name: _____ Ending Date / /

Time and Place	Foods Eaten	Duration (min)	Activity Performed	Duration (min)

Food and Activity Diary

Name: _____ Ending Date / /

Time and Place	Foods Eaten	Duration (min)	Activity Performed	Duration (min)

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: _____