

NEW CLIENT INTAKE FORM - PEDIATRIC

DEMOGRAPHIC INFORMATION

Child's name: _____ Birthday: _____
Lives with: _____
Address: _____
Parent/caregiver phone number(s): _____

Parent/caregiver email address: _____
Number of people living in household: _____
Grade in school: _____

Reason for visit with the dietitian: _____

Primary physician/healthcare provider(s): _____
Phone: _____

WEIGHT HISTORY

Please enter your child's current weight, height and any other weight-related history you'd like to share, such as growth patterns.

Weight: lbs Height/length: inches
Any recent weight gain or loss? Amount: Time frame:
Was this weight change intentional/unintentional? Please explain.

MEDICAL HISTORY

LAB RESULTS

Please enter your child's most recent lab results below, if applicable:

Lab Test	Results	Date Taken	Comments/Other Details
Total cholesterol			
LDL-cholesterol			
HDL-cholesterol			
Triglycerides			
A1c			
Blood sugar			
Hematocrit & hemoglobin			
Blood pressure			

MEDICAL HISTORY CONT.

Does your child have any chronic illnesses or medical conditions? Yes No
If yes, please specify:

Is your child allergic to any food or drinks? Yes No
If yes, allergic reaction to what?

Does your child have any of the following conditions:

Allergies	Anemia	Asthma	Diabetes
Digestive issues	Dry, itchy skin/rashes	Headaches	Hypoglycemia

MEDICATION

Does your child take any medications?

Any vitamins, supplements:

PHYSICAL ACTIVITY

Please describe your child's current physical activity (sports, activities, etc.):

DIETARY HABITS

Does your child follow any special diet? Yes No

If yes, what are the specific restrictions?

What type of milk does your child drink (skim, 2%, whole, non-dairy, etc.)?

What else does your child drink during the day?

How is your child's appetite? Excellent Good Fair Poor Varies

Does your child skip any meals? Yes No

If yes, which meals and why?

How many meals away from home does your child eat every day?

Which meals?

Does your child avoid any specific foods, such as meat or vegetables? Yes No

If yes, please specify:

If possible, describe a typical day for your child in terms of what he/she eats & drinks at meals and for snacks:

What are your child's favorite foods?

Least favorite foods?

Does your child eat candy, sweets, processed snack foods or soda? Yes No

If yes, please specify foods and amount per week (generally)

Who does the food shopping and cooking in your home?

What, if any, concerns do you have about your child's appetite or diet today?

SLEEP

Bedtime:

Hours per night:

OTHER QUESTIONS

What other questions to you have in regards to nutrition and diet?