Nutritional Assessment Questionnaire for Children

Name: ___________________________ Date: _______ / _______ / _______

Birthdate: ___________ Age: _______ Gender: ___________

Weight: ___________ Height: ___________ Percentile: ___________

Please list your three major health concerns in order of importance:
1. ________________________________________________________________
2. ________________________________________________________________
3. ________________________________________________________________

Please share three of your child’s strongest attributes:
1. ________________________________________________________________
2. ________________________________________________________________
3. ________________________________________________________________

FAMILY BACKGROUND
1. Yes ☐ No ☐ Has there been family stress or family conflict?
2. Yes ☐ No ☐ Has there been a recent job change in the family?
3. Yes ☐ No ☐ Has there been a divorce in the family?
4. Yes ☐ No ☐ Does any family member work over 60 hours/week?
5. Yes ☐ No ☐ Any family history of diabetes, kidney disease or asthma?
6. Yes ☐ No ☐ Any family history of heart disease, arthritis, or gallbladder disease?
7. Yes ☐ No ☐ Any family history of cancer? If yes, type of cancer: ___________________________
8. Yes ☐ No ☐ Any family history of stomach/intestinal disorders?
9. Yes ☐ No ☐ Have any family members ever been affected by substance use or abuse issues?
10. Yes ☐ No ☐ Has the child experienced recent changes -- births, deaths, divorce, remarriage, moves?

PRENATAL HEALTH
11. Yes ☐ No ☐ Any difficulties/stresses/illnesses during pregnancy?
12. Yes ☐ No ☐ Any medication taken during pregnancy? ___________________________
13. Yes ☐ No ☐ Any maternal history of Candida or bacterial infection that you are aware of?
14. Yes ☐ No ☐ Any alcohol, tobacco or drug use during pregnancy?
15. Yes ☐ No ☐ Mercury exposure during pregnancy (tuna/swordfish/sea bass consumption; dental work)
16. Yes ☐ No ☐ Non-vaginal delivery? If yes, did you have forceps/vacuum? ___________________________
17. Yes ☐ No ☐ Was baby delivered prematurely? If yes, how many weeks ___________
18. Yes ☐ No ☐ Were there any complications during delivery? ___________________________
19. Yes ☐ No ☐ Any medical problems at or immediately following birth? ___________________________
20. Yes ☐ No ☐ Any post-partum depression or psychosis?

HEALTH HISTORY
21. Yes ☐ No ☐ Did your child walk early (before 12 months)? If yes, what age? ___________________________
22. Yes ☐ No ☐ If an early walker, did your child skip the creep/crawl stage?
23. Yes ☐ No ☐ Did your child have any difficulty running (forward or backward)?
24. Yes ☐ No ☐ Any early toileting issues like diaper rash, frequent diarrhea or constipation?
25. Yes ☐ No ☐ Did your child experience colic or inconsolable crying?
26. Yes ☐ No ☐ Any early stomach upset, like frequent spit up or vomiting?
27. Yes ☐ No ☐ If vaccinated, did your child have any adverse reactions to vaccinations?
28. Yes ☐ No ☐ Has your child ever experienced eczema, dry skin or rashes?
29. Yes ☐ No ☐ Any cavities? If yes, how many? ___________ At what age(s) ___________________________
30. Yes ☐ No ☐ Has your child ever experienced a head injury, loss of consciousness, or seizure?
31. Yes ☐ No ☐ Does your child have any chronic medical problems?
32. Yes ☐ No ☐ Any serious injuries, surgeries or medical hospitalizations?
33. Yes ☐ No ☐ Is child currently taking any medicine or vitamins? Please list ___________________________
FOODS MY CHILD EATS: Please place an X in the appropriate column

<table>
<thead>
<tr>
<th>FOOD</th>
<th>Daily</th>
<th>3-5 times per week</th>
<th>1-3 times per week</th>
<th>Never or Almost Never</th>
<th>Used to eat, but not anymore</th>
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<tbody>
<tr>
<td>Artificial sweeteners</td>
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<tr>
<td>Candy, desserts, sugar</td>
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<tr>
<td>Carbonated beverages</td>
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<td>Caffeinated beverages</td>
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<tr>
<td>Essential fatty acid rich foods (avocados, flax seeds)</td>
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<td>Fruit Juice</td>
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<td>Fast foods</td>
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<td>Soy (tofu, veggie burger)</td>
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<td>Low fat foods</td>
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<td>Margarine</td>
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<td>Milk products:</td>
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<td>Chocolate milk</td>
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<td>Whole Milk</td>
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<td>2%, 1% or skim</td>
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<td>Cheese</td>
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<td>Bread, pasta, baked goods</td>
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<td>Vegetarian diet</td>
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<td>Vegan diet</td>
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<td>Meat</td>
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<td>Luncheon meats/hot dogs</td>
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<td>Fruit leather/granola bars</td>
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<td>Roasted nuts or seeds</td>
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<td>Fried foods</td>
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<td>Water, tap</td>
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<tr>
<td>Water, filtered</td>
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34. Was your child breast feed? Y N If yes, how long? _________ Any problems?______________________
35. If bottle-fed, what brand of formula?________________________________________ Begun at what age? __________
36. At what age were solid foods introduced?________________________________________
37. What were your child’s first foods?______________________________________________
38. What foods does your child crave?_______________________________________________
39. What foods does your child avoid?_______________________________________________
40. Does your child have constant need and desire for candy and sugar?_____________________
41. How does your child tolerate the introduction of new foods?__________________________
42. Any adverse reactions like fatigue or hyperactivity after eating certain foods?____________________
43. Is your child a picky eater about textures/temperatures?____________________________
44. Any known allergies to food?______________________________________________________
45. What percentage of your food is home cooked?______________________________________
46. How often do you eat out?________________________________________________________
47. How often does your family eat dinner together?____________________________________
48. Describe the typical atmosphere during meals?_______________________________________
49. Any other dietary concerns:_______________________________________________________
DIGESTION Please describe your child’s stool pattern (circle appropriate descriptions):

50. Frequency of bowel movements
   Less than one bowel movement/ day  One or more bowel movement/day  Diarrhea  Constipation  Alternating constipation and diarrhea

51. Stool Shape:
   Separate hard lumps, hard to pass  Sausage-shaped but lumpy  Ribbon shaped  Soft blobs with clear cut edges  Mushy stool

52. Stool Color:  Normal  Black or tarry colored  Light or clay colored  Whitish pale stools

53. Stool Texture:  Greasy or shiny stools  Undigested food in stool  Blood in stool  Mucus in stool

54. Gas:  None  Foul-smelling stools  Foul smelling gas  Stomach pains  Belching or gas after eating

SUGAR HANDLING
54. Yes ☐ No ☐ Awaken after falling asleep, can’t fall back asleep  60. Yes ☐ No ☐ Fatigue relieved by eating
55. Yes ☐ No ☐ Crave sweets
56. Yes ☐ No ☐ Binge or uncontrolled eating  62. Yes ☐ No ☐ Irritable before meals
57. Yes ☐ No ☐ Excessive appetite  63. Yes ☐ No ☐ Shaky if meals delayed
58. Yes ☐ No ☐ Crave sugar in the afternoon  64. Yes ☐ No ☐ Frequent thirst
59. Yes ☐ No ☐ Sleepy in afternoon  65. Yes ☐ No ☐ Frequent urination

ENERGY LEVEL (ADRENALS)
66. Yes ☐ No ☐ Do energy levels wane during the day? If yes, what time do they get tired?_________
67. Yes ☐ No ☐ Do specific foods make your child tired or bloated?
68. Yes ☐ No ☐ Is your child’s fatigue relieved by eating?
69. Yes ☐ No ☐ Is your child a slow starter in the morning?
70. Yes ☐ No ☐ Does your child tend to be keyed up, trouble calming down?
71. Yes ☐ No ☐ Is your child calm on the outside, but troubled on the inside?
72. Yes ☐ No ☐ Is your child chronically fatigued, or get drowsy often?

IMMUNE SYSTEM – Please check if your child experienced in his/her lifetime
84. Yes ☐ No ☐ Frequent colds or flu  91. Yes ☐ No ☐ Frequent Ear Infections
85. Yes ☐ No ☐ Sinus infections, congestion  92. Yes ☐ No ☐ Chicken pox
86. Yes ☐ No ☐ Mucus producing cough  93. Yes ☐ No ☐ Frequent antibiotics (more than 2x year)
87. Yes ☐ No ☐ Asthma, wheezing, difficulty breathing  94. Yes ☐ No ☐ Allergies and/or hives
88. Yes ☐ No ☐ Frequent runny or drippy nose  95. Yes ☐ No ☐ Itchy skin
89. Yes ☐ No ☐ Bronchitis, croup, respiratory issues  96. Yes ☐ No ☐ Never get sick
90. Yes ☐ No ☐ Strep throat? Croup, respiratory issues  97. Yes ☐ No ☐ Dark circles under eyes

MINERAL NEEDS
100. Yes ☐ No ☐ Bruises easily  107. Yes ☐ No ☐ Vomiting or nausea
101. Yes ☐ No ☐ Cuts heal slowly/ scar easily  108. Yes ☐ No ☐ Nose bleeds
102. Yes ☐ No ☐ Sunburn easily/ sun poisoning  109. Yes ☐ No ☐ Crave chocolate
103. Yes ☐ No ☐ Frequent fevers  110. Yes ☐ No ☐ Feet have a strong odor
104. Yes ☐ No ☐ Skin rashes/ dry flaky skin  111. Yes ☐ No ☐ Hoarseness
105. Yes ☐ No ☐ Craves salt  112. Yes ☐ No ☐ Gag easily
106. Yes ☐ No ☐ Pain or swelling in joints  113. Yes ☐ No ☐ White spots on fingernails
SOCIAL DEVELOPMENT

114. How does your child interact with other children?

115. How does your child interact with adults?

116. What makes your child happy?

117. What makes your child sad?

118. What makes your child angry?

119. What makes your child stressed?

120. How do you as a parent deal with these emotions in your child?

121. How does your child do in school academically?

122. How does your child do in school behaviorally?

123. What are your child’s favorite school activities?

124. What subjects or activities does your child struggle with?

125. Has your child ever harmed themselves intentionally? Harmed others?

BEHAVIOR/TEMPERAMENT: Please place an (X) next to any issues your child may demonstrate and note details.

<table>
<thead>
<tr>
<th>Description</th>
<th>Mild</th>
<th>Moderate</th>
<th>Severe</th>
<th>Unique Details</th>
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<tbody>
<tr>
<td>Aggression – hitting, biting, property destruction</td>
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<td>Anxiety -- worries, restless, scared, obsessive thoughts</td>
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<td>Defiance – talks back to adults, blames others, mean to peers</td>
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<td>Depression -- sad, irritable, hopeless, crying</td>
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<td>Difficulty sustaining attention, concentrating or organizing</td>
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<td>Difficulty handling transitions</td>
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<td>Excited, Hard to relax, lack of restful sleep</td>
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<td>Hyperactivity -- won’t sit still as if “motor running”</td>
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<td>Irritability/tantrums</td>
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<td>Lethargic - no energy, sluggish</td>
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<td>Lack of concern or regard for others</td>
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<td>Low self esteem – feels like failure, sensitive to criticism</td>
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<td>Mood Swings -- energetic, racing thoughts, too talkative</td>
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<td>Poor Impulse control/ frustration tolerance</td>
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<tr>
<td>Social anxiety -- shy, afraid to be around others</td>
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</table>
MEMORY/COORDINATION

66. Yes ☐ No ☐ Is your child’s mental speed slow?
67. Yes ☐ No ☐ Does your child have difficulty with learning or memory?
68. Yes ☐ No ☐ Does your child have difficulty with balance and coordination? slow movement?
69. Yes ☐ No ☐ Does your child have difficulty with visual memory?
70. Yes ☐ No ☐ Does your child have difficulty remembering locations?
71. Yes ☐ No ☐ Does your child have fatigue or low endurance for learning activities?
72. Yes ☐ No ☐ Does your child have difficulty with visual memory?

SLEEP PATTERNS

76. Yes ☐ No ☐ Does your child have difficulty falling asleep?
77. Yes ☐ No ☐ Does your child sleep soundly?
78. Yes ☐ No ☐ Does your child experience sleep apnea (trouble breathing while sleeping)?
79. Yes ☐ No ☐ Does your child wake up often in the middle of the night? What time?_________
80. Yes ☐ No ☐ Does your child’s body or limbs jerk as he/she falls asleep?
81. Yes ☐ No ☐ Does your child clench or grind teeth?
82. Yes ☐ No ☐ Does your child have frequent nightmares?
83. Please describe early sleep history (i.e. long naps/short naps, age stopped napping)_________

Is there any additional information you would like to share about your child?