NutritionWise

Nutrition Screening Questionnaire

Today's Date:_____

Child's Name:_____ Sex: Male/ Female

Birthdate:_____ Birthweight:_____pounds _____ounces

Was your child premature: Yes/No If yes, how many weeks early?_____

The following questions will help me learn more about your child's nutritional health. Please answer each of these questions: (circle the appropriate response)

1. How does your child appear to you: Overweight/Underweight/Just Right/Short

2. Is your child now on a special diet? Yes/No
If yes, what kind? _____

3. Is your child now allergic to or intolerant of any foods? Yes/ No
If yes, what foods? _____

4. Is your child now a "picky" eater? Yes/ No

If yes, circle all that apply:

Refuses many foods Drinks more than 40 oz milk per day
Refuses many solid foods Has a poor appetite Other: _____

5. Does your child now take any medications? Yes/ No
If yes, what medication(s)? _____

6. Does your child now take vitamins/minerals? Yes/No
If yes, name of supplement and dose: _____

7. Does your child have either of the following: Diarrhea Constipation

8. Does your child regularly vomit? Yes/No

9. Does your child have a feeding tube? Yes/No

10. Does your child have dental problems? Yes/No

11. Does your child have any feeding or eating problems?
Loses food from mouth Difficulty feeding self chokes on solids
Difficulty chewing foods Chokes on liquids Difficulty sucking
Using the bottle after 2 years Difficulty drinking from a cup

12. Is your child able to participate in physical activity? Yes/No
If yes, what type of activity and how often: _____
_____

13. How many hours of television does your child watch per day? _____

14. Do you have any additional concerns about your child's growth, nutrition or eating?_____
_____
_____