NutritionWise

Nutrition Screening Questionnaire

Today's Date:_____

Child's Name:_____ Sex: Male/ Female

Birthdate:_____

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 *Has a poor appetite
*Thinks foods are "good" or "bad" *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 anyone in your family have or ever had heart disease? Yes/No

9. Does your child eat when he/she is stressed or upset? Yes/No

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

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

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

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