Children's of Alabama

Nutrition Outpatient Diet History Form

Child's Name: _____
Caregiver's Name: _____ Relationship to Child:_____
Reason for Referral: _____

Please answer the following questions about your child's nutrition. ***Only answer questions that apply***.

Medical History

Does your child have any medical conditions or chronic illness? □ No □ Yes Please list_____

At birth, was your child premature? □ No □ Yes How many weeks?_____

Has your child ever seen a registered dietitian before? □ No □ Yes Where?_____

Does your child have any food allergies? _____

What happens when these foods are eaten? _____

Does your child take any medications on a regular basis? □No □Yes Please list_____

Does your child take a multivitamin or herbal supplement? □ Yes □ No

If yes, what? _____

Weight

What is your child's usual body weight? _____ When did his/her weight change?_____

What was his/her weight 1 year ago? _____

Is your child now on a diet to lose or gain weight? □ Yes □ No

If yes, what kind? _____

How long? _____

Who recommended this diet? _____

How do you feel about your child's weight? □ Okay □ Too heavy □ Too thin

How does your child feel about his/her weight? □ Okay □ Too heavy □ Too thin

Does your child take supplements/medication or use unhealthy lifestyle practices to keep their weight down?

□ Yes □ No If yes, what?_____ How often?_____

Diet History

Who usually buys groceries for the household? _____

Who usually prepares food/meals for the household? _____

Circle the cooking methods used most often in your home: fry bake broil roast grill steam

Diet History *(continued)*

Circle all of the fats you use in cooking: margarine/butter (brand/type:_____) shortening bacon oil (type:_____) cooking sprays fat replacements fat back other:_____

How many times *per week* does your family dine outside the home? □ none □ 0-1 □ 2-3 □ 4-6 □ 6 or more

What restaurants? _____

Does your child participate in the School Lunch Program? □ Yes □ No

School: _____ □ county school system □ city school system

Does your child participate in the WIC program? □ Yes □ No
Where?_____

Fill in the amount (number of ounces) your child usually drinks in one day. (Check all that apply)

Formula_____	Water_____	Juices_____	Milk_____
Soft drinks_____	Tea_____	Supplements_____	Sports drink_____

Does your child avoid any of the following food groups? _____Grains (cereal, bread, rice, pasta) _____Fruits _____Vegetables _____Dairy (milk, cheese, yogurt) _____Protein sources (meat, eggs, dried beans and peas) _____Fats (butter, salad dressings, oils)

Eating Habits

Do you have any concerns about your child's eating habits? _____

_____

How long *(in minutes)* does it take your child to finish a meal/feeding? □ < 10 □ 10-15 □ 15-30 □ ≥ 30

Where does your child eat **most** of their meals? □ High chair □ Kitchen table □ Living room □ On the run □ Front of the TV □ School/Daycare □ Other:_____

How often does your child skip: breakfast _____days/week
lunch _____days/week
dinner _____days/week

How would you describe your child's appetite? □ picky □ normal □ large

Does your child eat when he/she is: (Circle all that apply)
Hungry Not Hungry Bored Sad Happy Mad Frustrated/Anxious

Does your child ever sneak food, hide food, or wake up at night to eat? □ Yes □ No

Exercise

List the type, frequency, and length of physical activity that your child participates in:

Activity	How often (days/week)	How long (minutes)

How many *hours per day* does your child spend: watching TV _____ playing computer _____
playing video games _____ talking on phone _____
texting _____ reading _____

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