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

Revised 6/1/15 dmw
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 _________