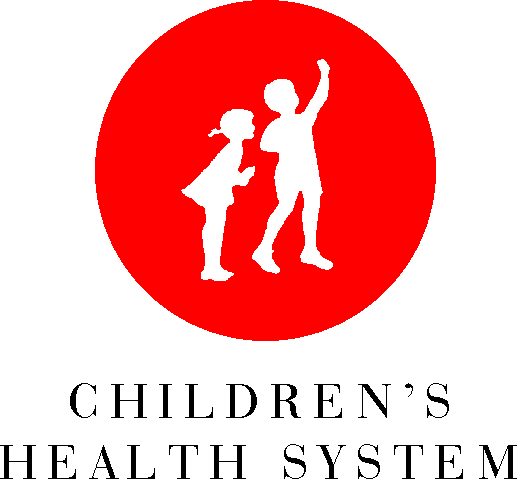
**Nutrition Outpatient Diet History Form**



®

Child's Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Caregiver’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Child:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for Referral: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please answer the following questions about your child's eating habits. Only answer questions that apply.

**Weight History**

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 ever vomit, take laxatives or diet pills to keep their weight down?

 Yes  No If yes, what?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How often?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Diet History**

Who usually buys the food for the household? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who usually prepares the food for the household? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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 eat fast food? \_\_\_\_\_\_\_\_\_\_\_\_\_\_Where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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\_\_\_\_\_

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**

How long does it take your child to finish a meal/feeding? \_\_\_\_\_\_\_\_\_\_\_ minutes

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

Any concerns about your child's eating habits? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**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 video games \_\_\_\_\_\_

playing on the computer \_\_\_\_\_\_

**Other**

Does your child have any food allergies? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What happens when these foods are eaten? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

If yes, what? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Nutritionist: Jennifer Heard, MS, RD Phone: 205-939-9204