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PEDIATRIC NUTRITION ASSESSMENT FORM Inova Center for Wellness and Metabolic Health

For Educator Use:

Ht: _____ Wt: _____lb

Patient Name: ____

Date of Birth:________________ **Today's date:**________________

Who cares for you in your home? ***(circle all that apply)*** Mother Father Grandparent Guardian Other ***(explain here)*** ____

EDUCATION:

What grade are you in school? ___ Do you go to after school program/care? ❑ Yes ❑ No

To help us focus on your needs, <u>please check all that you would like to know more about</u>:

- ❑ Healthy eating
- ❑ Choosing the right size portions of food
- ❑ Shopping and planning meals and snacks
- ❑ Weight gain/loss
- ❑ Getting and staying active

Is it difficult for you/your family to pay for food? ❑ Yes ❑ No
Do you have a computer/internet at your home? ❑ Yes ❑ No Do you have a "smart" phone? ❑ Yes ❑ No

MEDICAL INFORMATION:
Medication Allergies: ❑ None ❑ ***Specify*** ____

Medications, Vitamins, and Herbal Supplements:

Name	Doses and Times Taken Daily	Year Started
Example: vitamin D	*1000 units once a day (1 capsule)*	*2013*

HEALTH HISTORY: ***(Check all that apply)***

❑ high cholesterol
❑ vitamin D deficiency
❑ thyroid disease
❑ frequent upset stomach, nausea, vomiting, constipation, or diarrhea (***please circle all that apply***)
❑ asthma
❑ other ____

Does anyone in your family have diabetes? ❑ Yes ❑ No

Does anyone in your family have heart disease? ❑ Yes ❑ No

As health care providers, we are concerned about the safety of our patients so we ask every patient:

Do you feel safe at home? ❑ Yes ❑ No

Do you feel safe in your neighborhood? ❑ Yes ❑ No

Girls' Health:
❑ Have started menses ❑ Yes ❑ No (age at onset ____)
❑ Having regular cycles ❑ Yes ❑ No
❑ other (please explain) ____

Patient ID Sticker here

Immunizations:
Flu shot in the last 12 months? ❑ Yes ❑ No Month/Year __________ Other vaccinations__________________

Eating History:
How many times per week do you eat out? ❑ 0-1 ❑ 2-4 ❑5-8 ❑ Every day ____ times

What restaurants do you eat at frequently: ____

Do you have food allergies? ❑ Yes ❑ No ❑ ***Specify***____

Do you have other dietary restrictions? ❑ Yes ❑ No ❑ ***Specify***__________________________________

Does your family eat meals together? ❑ Yes ❑ No

Who decides what and when you eat? ____________________

Do you have trouble controlling how much you eat? ❑ Yes ❑ No

Do you ever eat because you are bored, upset, or unhappy? ❑ Yes ❑ No

Do you snack whenever you want to? ❑ Yes ❑ No

Usual Meal and Snack Times

Meals		**Time of Day**	**Snacks**		**Time of Day**
Breakfast	Yes/No		**AM Snack**	Yes/No	
Lunch	Yes/No		**PM Snack**	Yes/No	
Dinner	Yes/No		**Bedtime Snack**	Yes/No	

How often do you eat the following kinds of foods:

Fruit	❑never	❑____times a week	❑daily
Vegetables	❑never	❑____times a week	❑daily
Whole grains	❑never	❑____times a week	❑daily
Milk or yogurt	❑never	❑____times a week	❑daily
Soda/fruit drinks/sweet tea	❑never	❑____times a week	❑daily
Water	❑never	❑____times a week	❑daily

During the past two (2) weeks:	A Lot	Some	Little	Not at All
Have you often been bothered by feeling down, depressed, or hopeless?	❑	❑	❑	❑
Have you often been bothered by little interest or pleasure in doing things?	❑	❑	❑	❑

Physical Activity: What kind of physical activity do you get? ❑None ❑PE/recess ❑Sports ❑Other

How many days a week are you physically active? ❑None ❑1-2 ❑3-4 ❑5-6 ❑more than 6

How many minutes/hours are you physically active on these days? ❑16-30 ❑31-45 ❑46-60 ❑more than 60

For Teens:

Tobacco use: (Cigarettes, Cigars, Other) ❑ Never ❑ Former (quit____) ❑ Current (amount/day ____)

Do you have a job? ❑ Yes ❑ No

What work do you do? ________________________________How many hours a week do you work? _______

Participant/Parent or Guardian Signature _________________________________ Date/Time __________

Educator Signature ____ Date/Time __________