

Judy Converse, MPH, RD, LD
Nutrition Care for Children

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Your Name _____

1st Visit Date: _____

Your child's name _____

Address _____

What is the best way to reach you?

Home phone _____ Cel phone _____ E-mail _____

Who is this child's primary provider or pediatrician?

Primary Provider/Pediatrician
Address/Phone _____

Date of Birth _____ Wt at birth _____ Length at birth _____

Preemie? Yes No Concerns at delivery?

Please indicate: Breast Fed, to age _____ Formula Fed, from age _____

What formulas were used? _____

Current weight _____ Current Height or Length _____

Immunizations (check below, or attach a copy of immunization record)

- _____ Hepatitis B
- _____ Hib Influenza
- _____ DPT or DPaT
- _____ Polio
- _____ MMR
- _____ Varicella (chicken pox)
- _____ Rotavirus or Pneumococcal
- _____ Pediarix
- _____ Flu shots
- _____ Gardasil
- _____ Meningococcal
- _____ Hepatitis A
- _____ Other

Did your child have ear infections(indicate how many)?

Has your child had upper respiratory infections, asthma, or pneumonia?

Other infections requiring treatment (urinary tract, intestinal, eye, thrush, viral, cuts/wounds, etc.)?

Has your child ever needed antibiotics, antifungal medications (Nystatin, Gentian violet, Diflucan), or antiviral medications?

Has your child ever needed sutures, stitches, casts, or crutches?

Any surgeries, head injuries, or hospitalizations?

What medicines does your child use now (over the counter or prescription)?

Has your child used medications for mood, attention, or behavior?

What supplements or vitamins does your child take, if any?

What are your child's favorite foods? And least liked foods? (You may be asked to write down what your child eats for 2-3 days)

Diet restrictions, tube feedings, feeding problems (drooling, choking, gagging, reflux, assistance needed, pickiness), or other special diet measures:

Do you know if your child has any food allergies? If yes, which foods concern you?

Sleep pattern as a newborn to 6 months?

Sleep pattern, from 6-12 months?

Sleep pattern, 1-2 years?

Sleep pattern currently?

Sensory Disturbances:

Hearing ___ Vision ___ Taste ___
Proprioceptive ___ Vestibular ___ Olfactory ___
Praxis ___ Tactile ___

Is there a developmental, learning, or behavioral diagnosis? Yes No

Age at diagnosis: _____ What diagnosis was given? _____

Developmental concerns you have for your child:

Has your child needed assessment or treatment for seizures?

What therapies has your child used?

ABA	OT	OT with Sensory integration
PT	Speech/Language	Berard AIT Supplements
Medications	Tomatis	Social skills groups/RDI
Homeopathy	Special diets	Tomatis/Listening therapies

List any others you'd like to below:

What are your child's favorite activities? And least liked activities?

What would you most like to achieve with nutrition care for your child?