Emily Murray MS, RD, LDN
Nutritionist / Registered Dietitian
110 West Lancaster Avenue
Wayne PA 19087
(610) 574 – 0079
emilymurray1@gmail.com

Dietitian History Questionnaire and Assessment (Pediatrics)

General Information:

Child's Name: _____ Today's Date: _____
Parents'/Care Givers' Name(s): _____
Address: _____
Phone: _____ Phone #2: _____ Email: _____
Age: _____ Date of Birth: _____ Gender: _____
Reason for Appointment: _____

_____

_____

_____

Primary Care Provider: _____

_____

Address/Phone: _____

_____

Therapist: _____

_____

Address/Phone: _____

Referred by: _____
Grade in School: _____ Name of School: _____
Parent's Marital Status: ___ Single ___ Married ___ Divorced ___ Separated ___ Widowed
Parent's Occupation(s): _____
Siblings: Brother(s): _____ Ages: _____ Sister(s): _____ Ages: _____

Medical History:

Height: _____ Current Weight: _____
Growth History: _____

_____

Are you concerned with your child's weight? ___ Yes ___ No
Mother's Height: _____ Father's Height: _____
Are you concerned with your own weight? ___ Yes ___ No
Birth Weight: _____ Breast fed? _____ How long? _____
Bottle fed? _____ How long? _____ Formula: _____
Early feeding problems: _____

At what age were foods first introduced? _____

List complications: _____

_____

Food allergies/intolerances as an infant/toddler? ___ Yes _____ No

Please specify: _____

Symptoms: _____

Normal Pregnancy? ___ Yes ___ No List complications: _____

_____

Normal Delivery? ___ Yes ___ No List complications: _____

_____

Normal Growth/Development? ___ Yes ___ No List complications: _____

Please indicate whether your child or a family member have/had any of the following conditions:

Disease/Condition	Child	Family	Relationship	Treatment
Asthma				
Cancer				
Cardiovascular Disease				
Diabetes				
Drug Dependency				
Eating Disorder				
Food Allergies				
Food Intolerances				
Kidney Disease				
Headaches				
Heart Attack				
High Cholesterol				
Hypertension				
Intestinal Problems				
Menstrual Problems				
Mental Health Issues				
Obesity				
Osteoporosis				

Other _____

_____

List any medications your child is taking or has taken in the last year: _____

_____

Is your child currently taking any food supplements, vitamin, mineral, or herbal supplements? ___ Yes ___ No

If yes, please specify: _____

Menstrual History: (Female Patient):
Age began menstruating: _____ years of age _____ Have never menstruated
Date of last menstrual cycle: _____ Weight at that time: _____ pounds

Dieting History:
Has your child ever dieted? ___ Yes ___ No How many diets has your child been on? _____
Age of first diet: ___ years Weight at that time: ___ pounds
Why did your child go on the diet? _____

_____

Exercise History:
Does your child currently exercise/participate in sports? ___ Yes ___ No
Type, duration, frequency, and intensity of exercise activities: _____

_____

_____

What types of physical activities does your child enjoy?

_____

_____

Eating Habits:
How many days per week does your child eat:
Breakfast: _____ Lunch:_____ Dinner:_____ Snacks:_____
When does your child usually snack? _____
Does your child eat out (restaurants, take-out, fast food, etc.)? ___ Yes ___ No
How often? _____
List restaurants usually chosen: _____

_____

Does your child take lunch to school or buy lunch at school? _____
Examples of food choices: _____
Does your child eat snacks at school? ___ Yes ___ No What?

_____

Who is responsible for grocery shopping? _____
Who prepares/cooks the meals? _____
Do you read food labels? ___ Yes ___ No What do you look at on the label?_____

_____

Does your child eat standing up, walking, etc.?	_____ Yes	___ No
Does your child eat in the car, on the bus, etc.?	_____ Yes	___ No
Does your child eat in front of the TV?	_____ Yes	___ No
Does your child eat while reading, on the computer, etc.?	_____ Yes	___ No
Does your child eat with others?	_____ Yes	___ No
Does your child eat faster/slower than others?	_____ Yes	___ No
Does your child eat when stressed/bored/lonely?	_____ Yes	___ No
Does your child feel bad after eating?	_____ Yes	___ No

Does your child sneak food/hide food? _____ Yes ___ No
Does your child wish others wouldn't comment on what he/she ate? _____ Yes ___ No
Does your child feel like he/she eats differently than others? _____ Yes ___ No
Describe: _____

Does your child know what hunger & fullness feel like? _____ Yes ___ No
Does your child prepare his/her own meals? _____ Yes ___ No
Does your child avoid certain foods? _____ Yes ___ No
Please specify: _____

What are your child's favorite foods? _____

What food does your child dislike? _____

Please list your main concerns about your child's nutritional intake: _____

Family Weight History:

Are any members of your family overweight? ___ Yes ___ No Explain: _____

Are any members of your family underweight? ___ Yes ___ No Explain: _____

Does anyone in your family diet? ___ Yes ___ No Explain: _____

Did/Does anyone in your family have an eating disorder? ___ Yes ___ No
Explain: _____

Does your family eat meals together? ___ Yes ___ No Which meals? _____