healthy nest nutrition

Child's Intake (ages 3-14)

The information in this form will be strictly confidential. While it may feel time-consuming, please fill out each question thoughtfully in order to help us achieve a greater understanding of your health history, current issues, and nutrition goals. Parents—please fill this out for your child or with your child as best as you can.

Personal/Contact Information

Child's name:_____Date:_____Referred by:_____

Parent name: _____Address: _____

City: _____State: _____Zip_____

Parent Phone: _____Email: _____

General Health

Gender:_____Age:_____ Height:_____Weight:_____Stress Level (0-10):_____

What time of day is your energy the best? _____Worst?_____

How do you sleep? _____Bed time?_____ Wake time?_____

How often do you poop? Everyday 2X+ per day every other day infrequently

Do you have any known allergens? Y/N pls. list_____

Goals

What is your chief concern? _____

History

Were you breastfed as a baby? Y/N # of times you've had antibiotics?_____

Were you immunized Y/N If yes, any reactions? _____

List any medications & supplements currently taking:

Medication/Supplement	Taken for?	Helping?

Do you have a known diagnosis from your doctor? Please explain_____
Have you been diagnosed with any of the following?

☐ ADD/ADHD	☐ Autism	☐ Dysgraphia	☐ Obesity(High BMI)
☐ Ear infections	☐ Depression	☐ Aspergers	☐ Low BMI
☐ Eczema	☐ Dyslexia	☐ Migraines	☐ Other_____

Nutrition Habits

Please list your 10 most commonly eaten foods:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

What is your favorite food? _____

Typical Breakfast _____

Typical Lunch _____

Typical Dinner_____

Do you drink soda regularly? Y/N Do you drink water regularly Y/N

Who preps your meals? _____ Do you pack your lunch or BUY? _____

How often do you eat at restaurants? _____ Do you eat fast food? _____

I am going to be on your health team. Is there any thing else I should know?