Nutrition- Questionnaire

Child's name: _____

Date of birth: _____

Caregiver's name: _____

The reason for today's consultation: _____

Most recent weight: _____

Most recent height: _____

Does your child:	**No**	**Yes (please specify)**
1. have any medical conditions		
2. have frequent infections (such as ear infections, sinusitis, etc.)		
3. have skin issues (such as rashes, eczema, etc.)		
4. have concentration problems or a reduced attention span		
5. take any medications/supplement/natural products		
6. have any allergies or intolerances		
7. avoid any food (e.g. due to religious, cultural reasons, or preference)		
8. have/had a special diet		
9. enjoy eating		
10. throw his/her food		
11. spit out food		
12. accumulate food in mouth without swallowing it		
13. choke or cough while eating		
14. have difficulty staying at the kitchen table		
15. eat with distractions		
16. practice some physical activity		
17. sleep well		

In your family, are there people affected by the following conditions:	**No**	**Yes**
1. Diabetes		
2. Cardiovascular disease		
3. Obesity		
4. Anorexia		
5. Food allergies		

Thank you for filling out this questionnaire!