Agoo services familiaux et scolaires
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Pre-consultation Questionnaire (Nutrition)

Child's name: _____

Date of birth: _____

Parent's name: _____

The reason for today's consultation: _____

Most recent weight: _____**Most recent height:** _____

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

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