Northwest Family Nutrition

Please complete this Nutrition Screening form for your child and bring it with you to your appointment with the dietitian. If you have questions, please call 509-869-4737

Today's Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex: M F (circle)

Child Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Premature? yes no If yes, number of weeks \_\_\_\_\_\_\_\_\_ Birth weight \_\_\_\_\_\_\_\_\_ length \_\_\_\_\_\_\_\_\_\_

Child’s medical diagnosis\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medications \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Vitamins/Supplements\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Allergies\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Food Intolerances \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any problems during pregnancy\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Was alcohol or any drugs used before/during pregnancy by either parents? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your child receive WIC? yes no If yes, what location\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Current nutrition concerns about your child (please check all that apply)** Yes No Unsure

Seems underweight \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

Seems overweight \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

Frequent constipation \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

Frequent diarrhea \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

Frequent throwing up/vomiting \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

Takes longer than 30 minutes to eat \_\_\_\_\_ \_\_\_\_\_

Has trouble eating textured or chunky foods \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

Has trouble eating smooth foods \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

Has difficulty drinking liquids: formula/water/juice \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

Often chokes and gags on foods \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

Is a picky eater \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

If my child won’t eat, I make something different \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

I sit down with my child at meals \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

On a special diet, specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

Other concerns not specified?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**What Does Your Child Eat and Drink?**

1. Where do you usually feed your child? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. How many meals and snacks does he/she eat most days? \_\_\_\_\_\_\_ Meals \_\_\_\_\_\_\_\_ Snacks
3. Please check what your child eats:

\_\_\_\_\_ Breastmilk \_\_\_\_\_ Baby Cereal \_\_\_\_\_Ground Meats/Finely Ground Table Foods

\_\_\_\_\_ Formula \_\_\_\_\_Baby Foods \_\_\_\_\_ Cut-up Meats/Soft Table Foods

\_\_\_\_\_ Cow’s Milk \_\_\_\_\_ Junior Foods \_\_\_\_\_ Finger Foods

\_\_\_\_\_ All general foods

1. Circle the foods that you feel your child does not eat enough of:

Milk/Milk products Meat/Eggs Fruit Vegetables Bread/Cereals

1. How much does your child usually drink in one day (24 hours)

Water \_\_\_\_\_\_\_ Juice \_\_\_\_\_\_\_\_ Cow’s milk \_\_\_\_\_\_\_\_ Soda \_\_\_\_\_\_\_\_

Baby formula \_\_\_\_\_\_\_\_ What kind of formula? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How do you mix the formula? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Average time to finish a bottle/feeding \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please document all food and drink that your child eats for 3 days prior to your appointment.**

Please provide your measurements as close as you can for example: ¼ cup yogurt, 3 Tablespoons oatmeal with 1 Tablespoon of butter, 4 oz whole milk, 8 oz water. Thank you

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| --- | --- | --- | --- | --- |
| **Date/Time** | **Food Offered** | **Bottle/Drink Item Offered** | **Amount Consumed** | **Time to Complete Meal** |
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