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Pediatric Initial Input and Food Log

Date: _____

Patient Information

Name: _____ Date of Birth: _____
Legal Guardian: _____ ❑ Male ❑ Female

Personal Health Information:

Height: _____ Weight: _____

Usual Weight: _____ Weight History: _____
Bowel Habits: _____

Child's birth weight: _____ Child's birth length: _____

Gestational age: _____
Food allergies, if any: _____

Have you or your doctor ever been worried about your child's growth or weight gain? No: ☐ Yes: ☐ If yes, explain: _____

Has your child ever been hospitalized? No: ☐ Yes ☐ If yes, what for: _____

What, if any, medical diagnosis has your child been given by his paediatrician or other doctors?
_____

Did you child ever spit or vomit? If so, how often and how much?
_____

Has your child ever been diagnosed with reflux? If so, is he taking medications for this problem? Yes: ☐ No: ☐
Was your child ☐ breast-fed or ☐ bottle-fed? Any difficulties?
_____

At what age did you begin to offer baby foods? Did you have any difficulties with this transition? Explain:
_____

At what age did you begin to offer table foods? Did you have any difficulties with this transition? Explain:
_____

Is your child having regular bowel movements? Yes: ☐ No: ☐

Does your child have a feeding tube? If so, when was it inserted? _____

What formula and how much? _____

Does your child eat less than 30 foods? Yes: ☐ No: ☐ If yes, please list: _____
_____
_____

Does your child have strong reactions to certain foods (Tantrum, gag, vomit)? No: ☐ Yes: ☐ If yes, please list food(s) and reaction(s):
_____
_____

Does your child reject an entire group of foods? (Ex.: Will not eat any fruits or vegetables at all) No: ☐ Yes: ☐
If yes, which ones: _____

Is your child not able to touch certain foods? No: ☐ Yes: ☐
If yes, which one(s): _____

If your child rejects a certain food after eating it for an extended time does he/she have a hard time accepting the food again? No: ☐ Yes: ☐

Does your child ever wants to eat certain foods for many days at a time? No: ☐ Yes: ☐

- Does your child have other health concerns?
  _____
  _____
- Is he/she taking any medication? ❑ No ❑ Yes
  List: _____
  _____
- Has he/she ever seen a dietitian in the past?
  _____

- What are your goal(s) and expectations in meeting with a dietitian?
  _____
  _____

- Does your child have any food allergies, sensitivities or intolerances? ❑ No ❑ Yes

  If yes, please list and describe the symptoms:
  _____
  _____

Lifestyle Information

- Do you give him/her any supplements/vitamins/minerals? ❑ No ❑ Yes If yes, what?
  _____

- What is their general eating pattern?
  _____

- How many meals do you eat away from home each week?
  Breakfast: _____ Lunch: _____ Supper: _____

Food Frequency Questionnaire

How many times do you consume the following per day or per week (please specify the frequency as "/day" or "/week"):

Coffee/tea: _____ Juice/pop: _____ Water: _____ Added salt: _____
Milk: _____ Yogourt: _____ Cheese: _____ Salty foods: _____
Dairy (other): _____ Red Meat: _____ Processed meats: _____ Butter: _____
Fish: _____ Poultry: _____ Nuts: _____ Legumes: _____
Fruit: _____ Vegetables: _____ Grains: _____
What is your favourite food?: _____

Nutritional Diagnosis:

Plan:

Follow-up:

Diet History Day 1

Enter as much information as possible. Be precise: brand, exact quantity/portion size, cooking method.

Time	Meal/where	Foods/Beverages/Amounts
Ex. 7:45	Breakfast Kitchen	(EXAMPLE) 1½ cup of quick oats oatmeal, two tablespoons brown sugar, ¼ cup of 2% milk, pinch of salt
	AM Snack	
	Lunch	
	PM Snack	
	Supper	
	Evening Snack	