Susan Barendregt, Functional Nutritionist

www.susancnt.com
susan@susancnt.com
P: 608-433-0323 F: 608-338-0429

New Client Questionnaire (pediatric)

date: _____

name: _____ birth date: _____
address: _____ place of birth: _____
_____
parents: _____
phone h: _____ w: _____
cell: _____ school: _____
e-mail: _____ grade: _____

Names of people living with child	relationship to child	age

person to contact in an emergency name:
h:
c:
w:

Current Healthcare Practitioners

name	title	phone	reason for seeing	permission to contact?
				Y / N
				Y / N
				Y / N
				Y / N

Reason(s) for Seeking Nutritional Counseling

primary reason: _____
secondary reason: _____
other: _____
referred by: _____

Family Health History

	living(Y/N)	age	health issues
mother's mother			
mother's father			
father's mother			
father's father			
mother			
father			
siblings			

Health History

please answer to the best of your ability... use back of sheet if needed

height: _____ blood pressure: _____
weight: _____ blood type: A B AB O don't know

Is your child's growth appropriate? Y / N comments? _____

Complications with pregnancy or prematurity? explain. _____

Was your child breastfed? Y / N For how long? _____
Has child ever been on antibiotics? Y / N how many times? _____
Reasons for antibiotics: _____

List all **medications, vitamins, herbs and homeopathics** child is currently taking, dosage, reason for taking, and for how long.

List all significant **health issues** child has experienced, include approx. dates.

Surgeries?

Dental History (include info about amalgam "silver" fillings)

Describe your child's regular activities.

How is your child's sleep?

What time does (s)he go to sleep and wake up?

How does (s)he wake up?
i.e. grumpy, cheerful, still sleepy...
Does (s)he nap?

Do you have pets at home? Y / N what type?
Does child have any known allergies? Y / N
explain (including when started)

Any skin issues? (eczema, acne, dermatitis...) Y / N
describe

Food and Drink

How is your child's appetite?
How much water does (s)he drink per day? _____ what type? tap filtered
How much milk does (s)he drink per day? _____ what type? _____
How much juice does (s)he drink per day? _____ what type? _____
How much soda does (s)he drink per day? _____ what type? _____

How many meals does child have per day? _____ snacks? _____
Does (s)he eat at regular times each day? Or does it vary? explain:

List foods typically eaten for:
breakfast
lunch
dinner
snacks
What are his/her favorite foods?

Susan Barendregt, Functional Nutritionist susan@susancnt.com Fax: 608-338-0429

Does child have any dietary restrictions at present, either parent or physician imposed? Y / N
please explain. _____

Has child ever followed a special diet i.e. allergy elimination, gluten free, etc.?
Y / N explain: _____

Do any foods cause him/her physical symptoms? Y / N
Please explain.

Does (s)he have diarrhea? Y / N How often? _____
constipation? Y / N How often? _____
How many bowel movements does (s)he typically have in a day? _____
Is (s)he dry at night? Y / N During the day? Y / N
Problems with potty training? Y / N explain: _____

How would you describe child's energy level? _____

How are your child's social skills? _____

Anything else you'd like to add? _____