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Patient Nutrition and Health History

(Please type or print)

Date:

Personal and Confidential

Child's Name _____ Birth Date: _____

Sex _____ Age _____ Current Weight _____ Height _____

Parent(s) or Guardian(s) Name: _____

Address _____

Home Telephone Number _____ Mobile/Work Number _____

Email Address _____

Medical History:

Primary Diagnosis (if applicable) _____

Current Medications (if applicable) _____

Please check if **you or your child** has a history of any of the following health conditions?

- | | |
|--|---|
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> High Cholesterol (TC _____ mg/dl); (HDL _____) |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Other _____ |

Dietary and Physical Activity History:

Is child taking any vitamins/minerals, herbal or nutritional supplements? _____ If Yes, please list with dosage (mg/day) _____

Is child currently following a specific diet? (Gluten Free/ Casein Free, Low-Fat, Ketogenic, Soy Free etc) **YES** ___ **NO** ___ If YES, please explain _____

Does your child have any food allergies, intolerances or special nutrition concerns? **YES () NO ()**

If Yes, please explain _____

Does your child have any problem chewing or swallowing? **YES () NO ()** If Yes, please explain _____

Does your child have a history of constipation, diarrhea, gas or reflux? Please explain _____

How many meals and snacks does your child eat per day? _____

What are the beverages your child prefers most (i.e.: milk, soda, juice, fruit punch, water etc)? _____

Does your child consume any beverages or foods that contain artificial sweeteners (i.e.: Splenda (sucralose) , aspartame etc.)? Please explain _____

Has your child had any recent weight gain or loss in the last 6 months? **YES () NO ()**

If YES, please explain _____

Does your child participate in any type of physical activity? **YES () NO () N/A ()** If YES, what types? _____

If N/A, please explain the limitations that inhibit your child from exercising _____

Child's 3 Day Food Record

To the best of your ability, please record your child's food and beverage intake for 3 days. *Please be as specific as possible and list portion sizes (i.e.: ½ cup blueberry yogurt vs. yogurt or 4oz juice box, 100% apple juice vs. juice). Please be sure to list all snacks and treats as well (i.e.: 10 skittles, handful of French fries) Thank you!*

Day 1:

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

Day 2:

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

Day 3:

Breakfast _____

Lunch _____

Dinner _____

Snacks _____