Nutritional Therapy Questionnaire- Children only

This information will be treated as strictly confidential

This questionnaire will help assess how Nutritional therapy can help you with your health problems. Please answer all the questions adding any additional information at the back. You do not need to answer the questions. ***All information shared is treated with strict confidentiality****.*

General Information

Childs Name	**Parents Names**
Address	**Telephone Number** **Mobile** **Email**

Date of Birth	**Other siblings (age and gender)**
Does the child have a diagnosis or being assessed of a diagnosis? Give details	**Any other carers/ afterschool/grandparents**

Height **Weight** **Is childs weight stable, increasing or decreasing?**	**Have you had any blood tests recently? Why?** **Have your child experienced any digestive disorder as a result of travelling abroad?**
Permission to contact your medical doctor? **Is your medical doctor aware of your intention to see a Nutritional Therapist?**	**Doctors name and address** **Telephone number**

Health Profile

Please make a list of all the health concerns you would like to address, & indicate how long you have had these problems. E.g. Headaches, avoiding food groups, bloating 5 years.

	Health Concerns/Goals	**Duration**

What do you hope to achieve from the support of a Nutritional Therapist? Is your child interested in making changes or unaware?

Has your child or you any anxiety/fears or concerns about this lifestyle change?

What do you think has gotten in the way/is getting in the way for you so far to achieve health goals or address health issues?

Have you any ideas of what would make things easier for you that can help me to support you?

Do you have support from your partner, children, parents, and friends? (YES, some support, supportive but not like minded)

Does your child have any other unusual behaviours at home or outside the home that may be related to food difficulties if an issue?

MEDICATION

Please list <u>all</u> medication your child is <u>currently</u> taking and has taken in the <u>past</u> (remember to include the pill, antacids, painkillers, antibiotics, inhalers):			
Medication	**Prescribed by**	**Dosage / Frequency**	**Duration**

MEDICAL HISTORY

Please list your illnesses/operations (excluding colds and flu) starting from your childhood and including your present problems.

Your childs health history: illnesses and operations	Age of Onset	Duration	Related medication

If there is a family history of the following conditions please tick the appropriate box. Please add any other conditions if not included in the list

M= male F = female	Grandparents		Parents		Siblings		Cousins		Offspring	
	M	F	Male	Female	M	F	M	F	M	F
Heart Disease										
High Blood Pressure										
High cholesterol										
Osteoarthritis										
Rheumatoid arthritis										
Thyroid problems										
Osteoporosis										
Allergies										
Obesity										
Asthma										
Depression										
Alcoholism										
Cancer										
Type 1 Diabetes										
Type 2 Diabetes ('late onset')										

LIFESTYLE

Was your child breastfed?
Did your child have all the childhood vaccinations?
Did he/she have regular childhood diseases such as measles, chickenpox etc.
What has your child's diet been like? Please give details from birth till now
Would you consider your child to be a happy, active child?
Any Stressful situations or stress in the home?

Where does your child eat meals at home? Dining table/tv/bedroom **Is he/she involved in meal preparation/food choices?**
Do you as parents avoid any food groups that your child may be influenced by?

SYSTEMS PROFILE

Please read the following list of symptoms and fill in the number that applies:
(How significant is the symptom? How true is the statement?)
KEY
0= No or do not have the symptom, the symptom does not occur
1= Yes or it is a minor or mild symptom or it rarely occurs (once a month or less)
2= It is a moderate symptom or it occasionally occurs
3= It is a major symptom or it frequently occurs daily

DIGESTIVE TRACT PROFILE

	Belching Have you been able to associate it with anything in particular and/or foods?
	Heartburn (burning pain behind breastbone). How soon after you eat?
	Acid Reflux. How soon after you eat?
	Use of antacids (ie *Rennies* or *Gaviscon*). If yes, how often?
	Bad Breath
	Coated tongue
	Frequent stomach upsets. Have you been able to associate it with any foods in particular? Is it stress related?
	Stomach upset by taking vitamins
	Stomach upset by greasy foods
	Feel like skipping breakfast
	Feel better if you don't eat
	Finger nails chip or break easily
	Bloating. What situations make it worse? Do any foods make it worse? Does anything make it better?
	Abdominal pains or cramps associated with excess gas
	Abdominal pains or cramps **not** associated with excess gas
	Diarrhoea
	Alternating constipation and diarrhoea
	How many bowl movements do you have per day? If you experience less than one bowel movement per day, how many per week?
	Black or tarry stools

	Undigested food in stools
	Light clay coloured stools
	Greasy or shiny stools
	Anus itching
	Known history of parasites, worms or bacterial infestations
	Blood in stool. How long has this been occurring?
	Mucous in stool. How long has this been occurring?
	Have you had any GIT investigations such as an endoscopy or colonoscopy? Please indicate

LIVER PROFILE

	Frequent nausea
	Tendency to motion sickness
	Strong reaction to caffeine such as palpations, feeling jittery or keeping you awake?
	Sweat has a strong odour
	Strong reaction to medication such as antibiotics or the pill
	Haemorrhoids

ENDOCRINE (HORMONAL) SYSTEM

	Difficulty sleeping
	Require more than 8 hours sleep a night
	Hard to get going in the morning
	Frequent fatigue
	Frequent drowsiness during the day? Do think any foods make this worse? If yes, which foods. Do think any foods make this better? If yes, which foods.
	Dizziness or irritability if you don't eat often
	Frequent sweating
	Excessive thirst
	Loss of concentration and short attention span
	Poor memory or memory had deteriorated recently
	Reduced energy
	Tendency to depression or social isolation
	Intolerance to cold or heat
	Cold hands and feet
	Weight gain/difficulty losing weight
	Frequent headaches
	Rapid or irregular heartbeat
	Nervousness or anxiety
	Teeth-grinding
	Irritability
	Frequent migraines

IMMUNE PROFILE

	Runny or drippy nose. Do food and/or pollen that make this worse?
	Frequent infections/colds and flu's
	Frequent antibiotic use. How many courses have you taken?
	Frequent cystitis. If yes, how often?
	Frequent thrush. If yes, how often?
	Difficulty shaking off infections
	Never seem to get sick at all

	History of Epstein Bar, Herpes, shingles, Chronic fatigue, Hepatitis or other chronic viral conditions
	Inflammatory conditions. For example eczema, hayfever, asthma or arthritis. If yes, please name the condition/s
	Skin conditions such as eczema, acne or psoriasis. Do any situations or foods that make this worse?

LIFESTYLE PROFILE

Please answer the questions below as fully as possible to give us a clearer picture of your current lifestyle

SLEEP

How many hours sleep does your child get on average per night?
On average, what time does he/she go to bed?
Does this feel like enough?
Does he/she have difficulty falling asleep?
Does he/she wake in the night on a regular basis?
Does she/she watch tv in the room or have access to phones in the room/electronic devices?

Does he/she exercise or partake in sports? How often during the week?

DIETARY PROFILE – also see food checklist attached

EATING HABITS

In your household who does the majority of the cooking?
Do you avoid any foods/food groups for medical reasons?
How would you describe his/her appetite?
Does he/she ever eat simply because they are depressed and/or anxious?
Do you eat out a lot? How often?
How often do you eat take–away food? What type?

Foods that your child particularly likes	**Foods that your child particularly dislikes**

Please write down all the foods and drinks consumed over a 3-day period (it is advisable to include 1 weekend day), and the approximate times that they were consumed. Please also include your daily routine. For example what time you get up at, where and when you first eat etc.

Day 1
Breakfast What time did you get up? When and where did you have your breakfast? What did you eat and drink?
Lunch When and where? What did you eat and drink?
Dinner When and where? What did you eat and drink?
Drinks and snacks **Were you feeling stressed at any stage while eating today?** **Any physical Activity today?**

Day 2
Breakfast What time did you get up? When and where did you have your breakfast? What did you eat and drink?
Lunch When and where? What did you eat and drink?
Dinner When and where? What did you eat and drink?
Drinks and snacks

Were you feeling stressed at any stage while eating today? **Any physical Activity today?**
Day 3
Breakfast What time did you get up? When and where did you have your breakfast? What did you eat and drink?
Lunch When and where? What did you eat and drink?
Dinner When and where? What did you eat and drink?
Drinks and snacks **Were you feeling stressed at any stage while eating today?** **Any physical Activity today?**

Are there any foods or drinks that you consume regularly that did not appear in the food diary?

Are these days above typical or unusual days for you?

Please write any additional information here