Beach Street Centre

Your Health & Wellness Clinic

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Nutrition Assessment: Child

By accurately and in detail completing this questionnaire I can make more efficient use of your therapy sessions. Thank you for your time in filling out the new patient questionnaire. You can leave out any questions/pages if you wish, or write more if you feel there is any other relevant information you need add.

Name:		DOB	
Address			
Phone:		Email	
If you have a smart phone is it Apple/Android/Microsoft based? (Knowing this helps with providing information on Apps that may help with your Condition)			
Private Health Fund:		No:	
Medicare No. (if on a Care Plan)			
Height:	Weight:		
Today's Date:		Your Doctor is?	

Please provide a brief description of your main reason for this appointment:

Outline how your child’s condition has changed throughout life?	
What diets have you tried and what have been their effects?	
What diets have been recommended for your child and by whom?	
Are there any foods you know your child has an allergy/intolerance to?	
Food	Reaction to Food

Are there any foods which your child craves, feel addicted to, eat to excess?

How long did you breastfeed your child?	
If you used breast formula what was it based on e.g. diary, soy etc?	
Are you aware at what age (months/years) the following foods were introduced into your child's diet?	
Gluten	
Dairy	
Eggs	
Peanuts	
Tree Nuts	
Strawberries	

What behavioural difficulties do you believe will make changing your child's diet difficult? E.g Taste, food fears etc

Weekly Food Intake *(Tick the Box that most reflects the serving frequency your child eats the following food)*						
	1 or less	**2-3/Wk**	**4-6/Wk**	**Daily**	**2-3/Day**	**3 or More**
Beef						
Lamb						
Pork						
Chicken						
Other Poultry						
Fresh Fish						
Deep Sea Fish (Herring, Sardine, Mackerel, Tuna, Salmon etc)						
Other Seafood						
Eggs						

Citrus Fruit						
Stone Fruit						
Tropical Fruits						
Bananas						
Avocadoes						
Dried Fruits						
Tomatoes						

Leafy Greens						
Tuberous Veg. (Carrots, Parsnips, Beetroot, Squash etc)						
Cruciferous Veg. (Cauli, Broccoli, Cabbage, Brussel Spr.)						
Nightshades (Capsicum, Eggplant, Chilli)						
Starch Veg. (Potato, Sweet Potato, Corn)						
Onions/Leeks						
Mushrooms						

Peanuts						
Tree Nuts						

	1 or less	2-3/Wk	4-6/Wk	Daily	2-3/Day	3 or More
Beans						
Soy (including Tofu, Tempeh)						
Other Legumes (Lentils, Chick Peas)						
Milk						
Yoghurt						
Soft Cheese						
Hard Cheese						
Bread						
Pasta						
Breakfast Cereal						
Porridge (Oats)						
Rice						
Other Wholegrains						
Confectionaries						
Biscuits						
Cakes						
Chocolate						
Deep Fried Foods						
Fruit Juice						
Soft Drink						
Tea						

How often do you add the following to your Food?

	<1/Day	1/Day	2/day	Every Main Meal	Main Meals & Snacks
Salt					
Sugar or substitutes					
Dressings or Sauces					

What percentage of your foods do you eat raw?

None	<20%	20-40%	40-60%	60-80%	80-100%

Do you attempt to avoid foods with artificial colours and flavours?	Yes/No
Do you buy organic when possible?	Yes/No
Do your wash your fruit and vegetables	Yes/No

FOOD BEHAVIOURS

Who does the cooking at Home?

What is the size of the following main meals your child eats?

Breakfast: Small Moderate Large
Lunch: Small Moderate Large
Dinner: Small Moderate Large

How many snacks does your child eat per day?

Does your child often skip breakfast? Yes/No
Does your child regularly skip other meals? Yes/No
Which meal?
Why?

Does your child get hungry between meals? Yes/No
Do you child binge eat at any time? Yes/No
Does your child regularly hurry down meals? Yes/No

Do you eat out often? 1 or less/Wk 2-3/Wk 4-6/Wk Daily

When eating out does your child make Healthy Food Choices Yes/No

Do you specifically avoid certain food components (Circle)

Gluten Casein Lactose Salicylates Amines FODMAPs

Other:

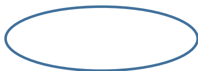
Why?

LIFESTYLE

How many hours sleep does your child get per day? When does your child go to sleep and wake up normally? Does your child follow a regular pattern of sleep or is it chaotic? Does your child have problems with sleep and if so, what are they?

On average how long does your child sit per day?	
On average how long does your child stand per day?	
How long is your child physically active without specifically exercising?	
Describe a normal exercise/sport week for your child?	
Are you satisfied with the amount of exercise your child is doing? If not, what would you like to change?	

What Pleasure Activities does your child enjoy and what are you Passionate about in life? What Motivates your child and what do you Reward yours child with?



Circle any **Medical Conditions** that you have or

Box Medical Condition where there is a **Family History?**

Heart Disease	High Blood Pressure	Low Blood Pressure	Diabetes
Asthma	COPD	Chronic Fatigue	Fibromyalgia
Cancer	Epilepsy	Depression	Anxiety
Osteoarthritis	Rheumatoid Arthritis	PMS	Menopause
Ankyl. Spondylitis	TMJ (Jaw) Problems	Hyperthyroid	SLE
Hypothyroid	Dementia	Alzhiemers Dis.	MS
Osteoporosis	Osteopenia	Mental Health	Incontinence
Irritable Bowel	IBD	Other Gastro (List)	Liver Disease
Psoriasis	Eczema	Lymphedema	Endometriosis
Migraines	Headaches	Anaphylaxis	ADHD/Autism

Any Other Medical Condition/Surgery?

Do you have any current illness such as cough, cold or flu? Yes/No

Is there any possibility you may be pregnant? Yes/No

List your Current Medication including Nutritional/Herbal Supplements?

GASTROINTESTINAL REVIEW Answer the following Question by Ticking or circling the appropriate box.				
	Always	Frequent	Occasional	Never
Hypoacidity				
Belching after Meals				
Gas after Meals				
Bad taste in mouth				
Bad Breath				
Poor protein digestion				
Loss of taste				

Hyperacidity				
Stomach Pain				
Hungry 1-2 hours after main meals				
Heartburn in lying				
Heartburn with spicy foods				
Antacid usage effective				
Milk reduces stomach pain				
Stress increases stomach symptoms				

Digestion (Dysbiosis/Enzymes/Candida)				
Bloating				
Cramping				
Nausea				
Undigested Foods in stools				
Fibre cause constipation				
Fruit causes discomfort				
Fat/yellow/greasy stools				
Antibiotic use				
Steroid use				

	Always	Frequent	Occasional	Never
Bowels				
Rectal Spasms				
Rectal Pain				
Diarrhea				
Constipation				
Abdominal pain relieved by bowel movements				
> 3 bowel motions/day				
Stress irritates bowels				
Bowel motion feels insufficient				

What is the colour of your bowel motions?

Do they float of sink?
Do they smell? Yes/No

Are they pebble like, thin and thready, mucusy, hard/soft?

Have you ever seen blood in your stools? Yes/No
If so, does your doctor know? Yes/No

Liver				
Pain under the right rib cage				
Abdominal Pain worse on Breathing				
Unexplained night itch				
Yellow skin or eyes				
Swollen feet or legs				

Candida				
White cover on tongue				
White cover vagina/under foreskin				

	Always	Frequent	Occasional	Never
Hypoglycemia/ Food Intolerances				
Poor Concentration				
Headache				
Low Mood				
Hyperactivity/ Irritability				
Weakness				
Restless				
Low Energy				
Sleepiness 1-2 hrs after meals				
Sugar snack to pick yourself up				
Non-specific Joint or Muscle Aches				
Sore Throat				
Breathing Changes after meals				
Hives				
Red Ears				
Mouth Ulcers				
Bags beneath Eyes				
Nasal Polyps				
Cystitis				
Itchy Anus				
Itchy Genitals				
Bed Wetting				
Hyperglycemia				
Frequent Toiletting				
>1 Night toileting				
Frequent Thirst				
Frequent Hunger				
Dizzy Spells				
Blurred Visions				
Slurred Speech				

Has your Doctor suggested or do you wish to trial any of the following diets (circle)?

Non-specific Healthy Eating Plan

Insulin Resistance

Weight Loss

Paleolithic

Autoimmune Paleo

Alkalising

Renal

GAPS

Gluten/Casein

Body Ecology

SCO

Low Stimulant

Milk Chocolate Free

FODMAPS

Low Salicylates

Detox

Candida

Low Residual

Other ____