CHILDREN'S NUTRITION QUESTIONNAIRE
Patient Information

Patient Name: ____________________________________DOB: __________Age:___
Father's Name: ______________________ Mother's Name: ______________________
Home Address: ______________________ Home Address: _______________________
___________________________________ ____________________________________
Phone: ______________________________ Phone: ______________________________
Employment: ________________________ Employment:_________________________
Address: ____________________________ Address: ____________________________
___________________________________ ____________________________________
Email:______________________________Email:_______________________________
Referred by: ____
Please provide an alternative telephone number other than home or work where you may be reached (other family member/friend:
____

Reason for Visit/Consultation: ____

Give detailed history of illness/problem, in consecutive order, if possible. Include date of onset, diagnosis and the treatment that has been tried and results. Please feel free to use another sheet of paper to complete this history.

____
____
____
____
____
____
____
____
____

Illnesses and symptoms/signs - please circle.

Ear infections
Sore throats
Sinus infections
Bronchitis
Pneumonia
Fevers
Tonsillitis
Bladder infections
Gastroenteritis
Asthma
Allergies
Headaches
Constant nasal or chest congestion
Noisy breathing
Mouth breathing

Vomiting
Diarrhea
Constipation
Rashes
Itchy skin
Wets bed
Strep throat
Irritable, cranky, cries a lot
Mood swings
Disruptive
Destructive
Behavioral changes
Sleeping problems
Poor appetite
Hyperactive
Poor attention
Short attention span
Clumsy
School problems with learning and/or behavior
Convulsions
Epilepsy
Growth delay
Early puberty changes (or delay)
Weight changes (gain or loss)

PRENATAL HISTORY:

Mother's health:

Mother's age:________ Mother's weight before pregnancy ____ Weight at term ____
(a) Before pregnancy____
(b) During pregnancy____
Please circle those problems you experienced -
Morning sickness
Skin health problems
Poor weight gain
Excess weight gain
High blood pressure
Gestational diabetes
Bladder infections
Yeast infections
Constipation
Anemia (hemoglobin, if known ____)
Respiratory problems
Sleeping problems
Leg cramps

Mother's habits: Smokes Drinks alcoholic beverages (wine, beer, hard liquor)
(Circle please.)
Medications/drugs used during pregnancy___________________________________
Before pregnancy__________________________________
Supplementation (vitamins and minerals):
Before pregnancy: During pregnancy:
________________________________ ___________________________________
________________________________ ___________________________________
________________________________ ___________________________________
________________________________ ___________________________________

BIRTH HISTORY

Delivery was (a) at home ____ (b) Hospital - Name: _____________________________
Address: ___________________________________
Labor and Delivery:
Birth weight _________ Birth length: ___________ Blood Type: _____________
On time ____________ Early__________ Late_____________
Natural __________ Induced _______ C-section _________
Normal/easy _______ Difficult, prolonged _______ how many hours: _________
If had C-section, please give reason(s):
____
____
Apgar score: ____________
Did your baby have any problems with breathing, eating, sleeping, BM, urinating or skin color?
____.
If answer is yes, please describe ____.
____
Did baby get sick while in the hospital?
____

INFANT FEEDING HISTORY

Baby's first feeding was (circle, please): Breast milk Formula
Glucose (sugared water) Sterile Water
Baby's nourishment:
Age 0 to 3 months: Breast milk Formula Mixed
Other _____________________________________
Age 3 to 6 months: Breast milk Formula Mixed
Other _____________________________________
Until what age was baby breastfed? ________________________________
At what age were solids introduced? ______ Months
What solids were started? Cereals Fruits Vegetables
Other_______________________________
When was meat introduced? ______ months
Cow's milk? ______ Months
What types of foods were introduced? ______packaged or jar baby foods
_______mother's home cooked baby foods
_______other
Vitamin & mineral supplements:
Brand________________________Which ones (i.e., multi, Vita C, calcium, etc.)
______________________________________Amounts given: _______________
At what age started: __________months

Any feeding problems? (Circle, please.)
Colic spitting up
Diarrhea constipation
Weight loss weight gain (excess)
Appetite (poor, good, excellent)
Food dislikes
Food cravings
Gas/bloating
Stomach aches
Belching
Allergy symptoms
(Nasal congestion)
Cough,
Rashes after eating a certain food
Behavioral changes associated w/feeding

NUTRITION/DIET HISTORY

On the average, what does your child eat for?
Breakfast: ____
Lunch:
____
Dinner: ____
Snacks, treats, drinks:
____
Does your child drink water? Yes/No what kind? Tap Bottled Distilled Purified
Does your child take vitamin and mineral supplements? Yes/No If yes, brand: ________

GROWTH AND DEVELOPMENT

Normal Early (Advanced) Delayed
Indicate whether physical, mental or emotional.
Describe your child's personality and behavior; peer and family relationship attitudes.
____
____
____
____
What physical activity or exercise does your child get every day?
____
How much sleep does your child get in an average day? If naps, average amount of time.

SCHOOL/ACADEMIC HISTORY:

Grade level: _______Elementary __________Middle _________High School
Regular Classes: Yes/No Special Education: Yes/No
Other (please explain):____
Performance: Poor Good Average Above Average

Describe in detail if diagnosed:
ADD Yes/No **LD** Yes/No **Developmentally Delayed** Yes/No **Other** _______

____

____

FAMILY HISTORY

Mother's age _____ Health _________________________ Occupation______________
Father's age______ Health _________________________ Occupation______________
Is/are parent/parents Single Married Unmarried Separated Divorced
Child's Custodian or Guardian: ___________________ Relationship to child: ___________
Birth order: ______
Siblings: Age Health
1.____________________________/_______/___________________________________
2.____________________________/_______/___________________________________
3.____________________________/_______/___________________________________
4.____________________________/_______/___________________________________

Family diseases:
High blood pressure heart disease Stroke
Diabetes
Arthritis
Cancer
Asthma
Allergies
Obesity
Other (please list):

____

____

Does any family member smoke? Yes/No drink alcohol? Yes/No

MEDICATION HISTORY

List any and all medications child is taking.

____

____

____

____

OTHER PERTINENT INFORMATION YOU WISH TO SHARE:

____

____

____

____

____
Signature
(Relationship to child)_________________________

YEAST QUESTIONNAIRE

Circle appropriate point score for questions you answer "yes." Total your Score and record it at the end of the questionnaire.

Name of Child ____ Point Score

(1). during the two years before your child was born, were you Bothered by recurrent vaginitis, menstrual irregularities, Premenstrual tension, fatigue, headache, depression, digestive Disorders or "feeling bad all over"?
30

(2). Was your child bothered by thrush? (Score 10 if mild, score 20 If severe or persistent?)
10
20

(3). Was your child bothered by frequent diaper rashes in infancy? (Score 10 if mild, score 20 if severe or persistent?)
10
20

(4). During infancy, was your child bothered by colic and irritability Lasting over 3 months? (Score 10 if mild, score 20 if severe or persistent?)
10
20

(5). Are his symptoms worse on damp days or in damp or moldy places?
20

(6). Has your child been bothered by recurrent or persistent "Athlete's foot" or chronic fungus infections or his skin or nails?
30

(7). Has your child been bothered by recurrent hives, eczema or other skin problems?
10

(8). Has your child received:

(a) 4 or more courses of antibiotic drugs during the past year? Or has he received continuous "prophylactic" courses of antibiotic drugs?
80

(b) 8 or more courses of "broad-spectrum" antibiotics ... (such as amoxicillin, Keflex®, Septra®, Bactrim® or Ceclor®) during the past three years?
50

(9). Has your child experienced recurrent ear problems? 10
(10). Has your child had tubes inserted in his ears? 10
(11). Has your child been labeled “hyperactive”? (Score 10 if mild, score 20 if severe or persistent?)
10
20
(12). Is your child bothered by learning problems (even though his early developmental history was normal)?
10
(13). Does your child have a short attention span? 10
(14). Is your child persistently irritable, unhappy and hard to please?
10
(15). Has your child been bothered by persistent or recurrent digestive problems, including constipation, diarrhea, bloating or excessive gas? (Score 10 if mild, 20 if moderate; 30 if severe)
10
20
30
(16). Has he/she been bothered by persistent nasal congestion, cough and/or wheezing?
10
(17). Is your child unusually tired or unhappy or depressed? (Score 10 if mild, 20 if severe)
10
20
(18). Has your child been bothered by recurrent headaches, abdominal pain, or muscle aches? (Score 10 if mild, 20 if severe)
10
20
(19). Does your child crave sweets? 10
(20). Does exposure to perfume, insecticides, gas or other chemicals provoke moderate to severe symptoms?
30
(21). Does tobacco smoke really bother him? 20
(22). Do you feel that your child isn’t well, yet diagnostic tests and studies have not revealed the cause?
10

TOTAL SCORE

Key for scoring:

(1) Yeasts possibly play a role in causing health problems in children with scores of 60 or more.

(2) Yeasts probably play a role in causing health problems in children with scores of 100 or more.
(3) Yeasts almost certainly play a role in cause health problems in children with scores of 140 or more.