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Nutrition Care for Children
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Phone 303-842-8255 **Fax** 303-474-6502

Your Name_____

1st Visit Date:

Your child's name

Address_____City/Town_____

State/Zip _____

Home phone _____ Cel phone _____ E-mail_____

OK to speak with your child's Primary Provider/Pediatrician (Address/Phone)?

_____

Has your child been seen by:

Gastroenterologist Neurologist Allergist DAN doc

Psychologist Speech/Language Pathologist OT / PT

Metabolic Specialist Developmental Peds Specialist

Child's current weight: **Current height or length:**

Date of Birth: **Birth Wt:** **Length:**

Preemie? Yes No Concerns at delivery? Yes No

Breast Fed, to age_____ Formula Fed, from age_____

What formulas?_____

Did your baby receive newborn Hepatitis B vaccine? Yes No Don't Know

Circle any that applied in pregnancy/delivery: Antibiotics Any meds

Yeast infection Group B Strep C-section Any vaccine

Other vaccines Baby spent time in NICU Jaundice

Other concerns during pregnancy / delivery?

Infections/Illness/Injuries…

How many ear infections has your child had?

List upper respiratory infections, asthma, or pneumonia episodes?

Other infections requiring treatment (urinary tract, intestinal, eye, thrush, viral, cuts/wounds, etc.)?

Has your child ever needed antibiotics, antifungal mecications (Nystatin, Gentian violet, Diflucan), or antiviral medications?

Sutures, stitches, casts, or crutches?

Any surgeries, head injuries, or hospitalizations?

What medicines does your child use now (over the counter or prescription)?

Has your child tried medications for mood, attention, or behavior?

List supplements or vitamins your child takes now:

What are favorite / least liked foods?

Diet restrictions, tube feedings, feeding problems (drooling, choking, gagging, reflux, assistance needed, pickiness), avoided foods, or other special diet measures:

Do you know if any food allergies? If yes, which foods? If lab tests have been done, please fax these to 303-474-6502 or send via e mail.

Sleep pattern as a newborn to 6 months?

Sleep pattern, from 6-12 months?

Sleep pattern, 1-2 years?

Sleep pattern currently?

Sensory Concerns – check those that apply:

Hypersensitive to noise Hypersensitive to light Vestibular

Hypersensitive to smell Tactile defensive Oral tactile defensive

Difficulty with visual tracking Gross motor concerns

Is there a developmental, learning, or behavioral diagnosis? Yes No

Age at diagnosis: _____ What diagnosis was given? _____

Developmental concerns you have for your child:

Has your child needed assessment or treatment for seizures?

Check any that apply for your child:

Fingernails:

____pink ____grey/blue ____white spots on nails

____cracked/peeling/split ____soft _____hard

____spoon shaped (concave) ____flat ____hang nails ____fungus

Hair:

____stiff ____dry ____limp ____thick

____soft ____thin ____brittle

Face:

____rosy cheeks ____red dots/bumps ____red splotches

____white splotches ____raised white dots ____no bumps

____eczema ____crusts around eyes ____tongue red/glossy

____dark circles under eyes ____grey/blue around lips or nostrils

____drooling ____tongue coated white or grey ____tongue smooth/bumpy

Trunk/Skin:

____hard white dots ____rashes of any kind ____eczema

____itchy ____not itchy ____bloating

Stools:

____unformed, loose ____mucousy, stringy, or glossy ____hard, dry

____painful defecation ____foul smelling ____float ____sink

____foamy, frothy ____blood visible frequency? _____

Color (circle one)? grey brown green gold black; pale or dark?

Current or past therapies (circle any that apply)

ABA OT/ PT Sensory integration Hippotherapy

Usman Protocol Speech/Language Yasko Protocol DAN/Biomed

Medications Social skills groups/RDI NAET Supplements

Homeopathy Special diets Tomatis/Berard/Listening therapies

Lyme disease assessment or care

List any others you'd like to below:

What are your child's favorite / least liked activities?

What would you most like to achieve with nutrition care for your child?