Nutrition Questionnaire for Children The Orpheus Clinic
Yuliya Klopouh, Pharm.D.

Name: _____ Age: _____ Date of Birth:_____

Weight _____ Height _____

Reason for Nutrition Evaluation
_____
_____
Please list any previous or current medical issues your child has.
_____
Please list any food allergies or intolerances your child has.
_____

Has your child experienced any recent weight gain or loss? Y N If so, how much in how long? _____

Please list any medications, nutrition supplements or vitamins that your child is currently taking: _____
_____
_____
Does your child have any issues with: __ Constipation __ Diarrhea __Vomiting __Reflux?

1. How would you describe your child's appetite?
   __Good __Fair __Picky

2. How many days does your family eat meals together per week?
   ____ 1-2 x/day ____ 1x/day ____ 3 or more x/week ____1x/week ____hardly ever

3. How many meals does your child eat per day? _____
4. How many snacks per day? _____

5. Which of these foods did your child eat or drink last week? (Check all that apply.)
   Grains
   __Bread __Rolls __Biscuits __Bagels
   __Muffins __Tortillas __Crackers
   __Rice/ pasta/ noodles __Ready to eat cereal
   __Other grains __Cooked cereal

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Vegetables

__Corn __Peas __Green beans
__French Fries __Potatoes __Tomatoes
__Carrots __Broccoli __Green salad
__Greens (collards, spinach) __Other vegetables:

Fruits

__ Apples __ Oranges __ Grapefruit
__ Grapes __ Peaches __ Melon
__ Pears __ Bananas __ Other fruits:
__ Juice: _____

Milk and Other Dairy Products

__Whole milk __Yogurt
__Reduced-fat (2%) milk __ Cottage

Cheese

__Low-fat (1%) milk __Cheese
__Fat-free (skim) milk __Ice cream
__Flavored milk
__Other milk and dairy items:
_____

Meat and Meat Alternatives

__Beef/hamburger __Pork __Sausage/bacon
__Chicken __Turkey __Cold cuts
__Fish __Eggs __Dried Beans
__Peanut butter __Tofu
__Other meat and meat alternatives:_____

Fats and Sweets

__Cookies __Cake/cupcakes __Pie
__Chips __Doughnuts __Candy
__Fruit-flavored drinks __Soft drinks __ Fruit Rolls
__ Butter __ Margarine __ Mayonnaise
__Other fats and sweets:
_____

6. How much juice does your child drink per day? __ ounces/day __ cups/day
How much sweetened beverages (for example, fruit punch, iced tea and soft drinks) does your child drink per day? __ ounces/day __ cups/day

8. Does your child take a bottle to bed at night or carry the bottle around during the day? __Yes __No

9. What is the source of the water your child drinks?
__ public __ well __ commercially bottled __ home system-processed water

10. Does you child participate in physical activity (for example, walking or riding a bike) in the past week? If yes, on how many days and for how long?
__Yes __ days/week __minutes/day __No

11. Does your child spend more than 2 hours per day watching television, videos or playing computer games? If yes how many hours per day?
__Yes __ hours/day
__No

12. Does your child choke, gag or have difficulty swallowing when eating?
__ Yes, Please explain: _____
__ No

13. Does your child have any food allergies?
__ Yes If so, what are they? _____
__ No

14. Do you have any concerns about your child's height or weight?
_____