Vitalia HEALTHCARE

NATASHA ASSELSTINE
HOLISTIC NUTRITION

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PEDIATRIC NUTRITIONAL INTAKE FORM

(For children up to the age of 12 years)

Date: _____ Name of child: _____

Birthdate: *(MM/DD/YY)* _____ Sex: _____ Weight: _____ Height: _____

Street Address: _____

City: _____ Province: _____ Postal Code: _____

Parent/Guardian Phone: *(H)* _____ *(W)* _____ *(C)* _____

Parent/Guardian Email address: _____

Preferred method of contact? (Please circle one) Email / Phone

How did you hear about us? _____

Would you like to be included on Vitalia's e-newsletter distribution list to be kept up-to-date on Vitalia promotions, wellness news and other happenings? *Yes / No*

What are your child's main health concerns? *Please list in priority.*

_____

_____

_____

What would you like to achieve by coming here today? _____

_____

Has he/she ever been diagnosed with an ailment related to their main health concern(s)? *Yes / No* If **yes**, please describe: _____

Has there been any trauma or loss in the past 5 years? _____

Does your child live with you: full time? _____ part time? _____

Is your child adopted? *Yes / No*

What level of stress is your child experiencing at this time? *Possible signs of stress include anxiety, nightmares, overreactions, difficulty leaving you, new unhealthy patterns, etc.*

_____

What are the major causes of his/her stress? _____

How does your child's stress manifest itself? _____

Do he/she have any coping mechanisms? _____

What does your child do for exercise? _____ How often? _____

How many hours on average does your child sleep daily? *(Include naps)* _____

What time does your child go to sleep at night? _____ Awaken? _____

Does your child sleep through the night? *Yes / No* Awaken feeling rested? *Yes / No*

What does your child do for extra-curricular activities? _____

Does he/she enjoy these activities? *Yes / No*

How many hours a week does your child do these activities? _____

What are your child's interests/hobbies (other than the extra-curricular activies)?

_____

Does anyone in your household smoke? *Yes / No*

Is your child regularly in the care of someone other than your spouse, i.e. daycare? _____

How many hours does your child spend, on average:

in the car _____ *watching tv* _____ *reading* _____ *in front of the computer* _____

MEDICAL HISTORY

Please list any vitamins, minerals, herbal or homeopathic remedies your child is currently taking and the amounts/dosages: _____

_____

List any nutritional supplements that your child is currently taking (herbal and homeopathic as well): _____

Does your child have any allergies or sensitivities? *Yes / No* If **yes**, please list:
**** Please also indicate any anaphylaxis (life-threatening) allergies****

_____

Does your child have any silver-mercury fillings? *Yes / No*

Does your child have a history of any prenatal drug/alcohol exposure? *Yes / No*

Has your child ever been:

a) Diagnosed with an illness? *Yes / No* If **yes**, please explain: _____
b) Hospitalized? *Yes / No* If **yes**, for what reason? _____

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How often does your child have a bowel movement? _____

Does he/she strain to have a bowel movement? *Yes / No / Sometimes*
Related to a particular food or circumstance? _____

Does he/she have loose bowel movements? *Yes / No / Sometimes*
Related to a particular food or circumstance? _____

Please check all that apply to your child:

ADD/ADHD ____
Allergies (environmental) ____
Allergies (food) ____
Asthma ____
Autism ____
Blue Baby ____
Bronchitis ____
Chicken Pox ____
Colic ____
Croup ____
Dental problems ____
Developmental problems ____
Diarrhea ____
Ear infections ____
Frequent colds ____
Impaired speech ____
Jaundice ____
Measles ____
Meningitis ____
Mumps ____
Neural Tube Defect ____
Pneumonia ____
Rubella ____
Rheumatic Fever ____
Scarlet Fever ____
Tonsillitis ____
Thrush ____
Whooping cough ____
Other (specify):
_____

SYMPTOMS: *(Mark "C" for current and "P" for past symptoms)*

____ Abdominal ain
____ Acid reflux
____ Anemia
____ Bad breath
____ Bed wetting
____ Bleeding gums
____ Blood in urine
____ Body odour
____ Bruises easily
____ Canker sores
____ Changes in appetite
____ Congestion
____ Constipation
____ Cough
____ Cries easily
____ Diarrhea
____ Dizzy spells
____ Dry skin
____ Eczema
____ Excessive fatigue
____ Excessive perspiration
____ Flat feet
____ Frequent headaches
____ Gas
____ Hearing loss
____ Heart murmur
____ High fevers
____ Hives
____ Hyperactivity
____ Itchy anus
____ Itchy nose (or picks nose)
____ Itchy vagina
____ Jaundice
____ Joint pains
____ Migraines
____ Motion sickness
____ Nervousness
____ Nightmares
____ Night sweats
____ No appetite
____ Nosebleeds
____ Painful urination
____ Parasites
____ Psoriasis
____ Rash
____ Sensitive to light
____ Sleep problems
____ Stomach aches
____ Sore throat
____ Teeth grinding
____ Talks in sleep
____ Walks in sleep
____ Weight gain
____ Weight loss
____ Wheezing
____ Vomiting spells

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MEDICATIONS: *(Include length of time child received each medication)*

- ____ Antacids
- ____ Antibiotics
- ____ Antidepressants
- ____ Anti-Histamine
- ____ Aspirin
- ____ Clonidine
- ____ Declectin
- ____ Decongestant
- ____ Dextroamphetamine *(Dexedrine, Dextrostat, Adderall)*
- ____ Epilepsy medication
- ____ Ibuprofen
- ____ Inhaled Steroids
- ____ Methylphenidate *(Ritalin)*
- ____ Oral Steroids
- ____ Pemoline *(Cylert)*
- ____ Tylenol
- ____ Others *(Please list)*

_____

Please list any allergies to medications that you are aware of:

_____

IMMUNIZATIONS: *(Check all that apply)*

- ____ Diptheria
- ____ DPT
- ____ Hemophilus
- ____ Hepatitis
- ____ Hib *(Hemophilus Influenza)*
- ____ Influenza
- ____ Measles
- ____ MENI *(Meningococcal disease)*
- ____ MMR *(Measles, Mumps, Rubella)*
- ____ Mumps
- ____ IPV *(Polio)*
- ____ PNEU *(Pneumococcal disease)*
- ____ Small pox
- ____ Tetanus
- ____ VAR *(Varicella or chicken pox)*

Were there any reactions to immunization(s)? If so, at what age?

_____

FAMILY HISTORY:

Please indicate any hereditary diseases. Use" F" for Father, "M" for Mother, "S" for sibling, "G" for grandparent, "O" for others:

Allergies _____
Alcoholism _____
Arthritis _____
Asthma _____
Diabetes _____
Gall Bladder Issues _____
Heart Disease _____
Hypertension _____
Intestinal Disease _____
Kidney Dysfunction _____
Mental Illness _____
Osteoporosis _____
Skin Conditions _____
Ulcers _____

Cancer – Type: _____

Other: *(please list)* _____

MOTHER'S HEALTH DURING PREGNANCY: *(Check all that apply)*

- ____ Alcohol, cigarettes, drug consumption
- ____ Anemia
- ____ Bleeding
- ____ Dental problems
- ____ Diabetes
- ____ Gestational Diabetes
- ____ Hypertension
- ____ Nausea
- ____ Physical or emotional trauma
- ____ Pre-eclampsia
- ____ Stress
- ____ Thyroid problems
- ____ Uterine infection
- ____ Other: (please specify)

_____

_____

Please list any medications taken while pregnant: _____

_____

Please list any medications taken while nursing: *(mother)* _____

_____

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TERM:

Full _____ Premature_____ Late _____
Weight of child at birth _____ lb

LABOUR + DELIVERY:

Was labour induced? *Yes / No*
Vaginal ____ C-Section ____ Complications during labour? _____

CHILD'S DIETARY HABITS:

Breast fed _____ Bottle fed _____

When was formula started? _____ When were the first foods introduced? _____
What were they? _____

How many meals a day does your child eat?
Main meals _____ Times of day: _____
Snacks _____ Times of day: _____

Does your child eat... *(Check all that apply)*

_____ with family? _____ at restaurants? _____ on the run?
_____ alone? _____ fast food?

Are there any restrictions to your child's diet due to preferences of others such as family, others living with you, etc.? *Yes / No* If **yes**, please describe: _____

_____

Is your child a meat eater, vegetarian, vegan, or on a specific diet? _____

How often does he/she eat meat? ___ Daily ___ 3-5 x/wk ___ Once or less than a week
Dairy products? ___Daily ___ 3-5 x/wk ___Once or less than a week

How many **1 cup** servings of the following does your child typically eat in a day?

Fruit *Fresh:* _____ *Dried:* _____ *Canned:* _____
Vegetables *Raw:* _____ *Cooked:* _____
Whole Grains: _____ *Type:* _____
Protein: _____ *Type:* _____
Dairy: _____ *Type:* _____
Good Fats: *(nuts, seeds, avocado, olive oil)* _____ *Type:* _____
Other (please specify): _____

How many **cups** of the following does your child typically drink in a day?

Tap water _____
Bottled or spring water _____
Tea _____
Herbal tea _____
Soft drinks *(diet)* _____
Soft drinks *(regular)* _____
Fresh fruit or vegetable juices _____
Fruit or vegetable juices *(prepared)* _____
Milk *(1% or 2%)* _____
Milk *(skim)* _____
Other _____

Indicate how frequently *(1 for rarely, 2 for regularly, 3 for often)* your child eats or uses:

Aluminum pans _____
Microwave _____
Luncheon meats _____
Artificial sweeteners _____
(Nutra sweet, Aspartame, Splenda)
Margarine _____
Refined foods _____
(pastries, cookies, white bread/pasta/rice, etc.)
Fried foods _____
Candy and chocolate bars _____
Fast foods _____

Please provide examples of your child's typical meals:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

What are your child's favourite foods? _____

How often does he/she eat them? _____

Does your child avoid any foods? *Yes / No* If **yes**, which ones and why?

_____

Does your child experience symptoms if meals are missed? *Yes / No* If **yes**, please explain:

_____

Does your child experience any symptoms after meals? *Yes / No* If **yes**, please explain:

_____

What do you think is contributing to your child's main health concerns?

_____

Thank you very much. All information contained in this form is kept strictly confidential.

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