Patient Intake Form

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Please fill in all the information as accurately as possible. The information you provide will assist in formulating a complete health profile. All answers are confidential.

PATIENT INFORMATION

First Name _____ Last Name _____ Date of Birth _____

PARENT INFORMATION

First Name _____ Last Name _____

Home Phone ( ) _____ Cell Phone ( ) _____

Address _____

Email _____ Referral Source _____

DOCTOR INFORMATION

Primary Care Physician

First Name _____ Last Name _____

Phone Number ( ) _____

Address _____

HEALTH INFORMATION

Height _____ Weight _____ Goal Weight _____

Please list your child's food and nutrition concerns which prompted your appointment.

_____

_____

Please list any medications or vitamin supplements your child is taking.

_____

_____

Does your child have any food allergies or intolerances?

NUTRITION QUESTIONNAIRE

Is your child flexible, moderate, or rigid with their food choices?

Does eating out at restaurants present any challenges?

Does your child tend to eat better with people or when alone?

How do family members or friends influence your child's food choices?

PHYSICAL ACTIVITY QUESTIONNAIRE

Please list the types and frequency of activity your child participates in on a regular basis.

FOOD QUESTIONNAIRE

What does a typical day of food consumption look like for your child?

Breakfast

Lunch

Dinner _____

_____

Snacks _____

_____

Beverages _____

_____

Please list the typical choices within each food group.

Proteins _____

_____

Grains/Breads _____

_____

Fruits _____

_____

Vegetables _____

_____

Fats _____

_____

How often does your child eat sweets and if so which types?

_____

_____

What foods does your child crave?

_____

_____