

CHILD NUTRITIONAL THERAPY QUESTIONNAIRE

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This questionnaire is designed to provide your nutritional therapist with all the information necessary to build your child an individual nutritional programme tailored to his/her specific needs. Please answer the questions as accurately as you can.

Child's First Name: _____ Last Name: _____ DOB: _____

Address: Postcode: Telephone Home: Parent/Carer Work: Mobile: Email:	GP Name: GP Address: Postcode: Telephone: Is your GP aware you are consulting a nutritional therapist? YES/NO Are you happy for your GP to be kept informed? YES/NO
Any other health professionals involved in your child's care:	
Weight: _____ Height: _____	Age (years and months): _____

MAIN REASONS FOR VISIT:

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FAMILY PROFILE

Mother's Name:	Age:	Occupation:
Health Problems:		Are you the birth mother?
Father's Name:	Age:	Occupation:
Health Problems:		Are you the birth father?
Brothers/sisters:		
Male/Female: _____	Age: _____	Health problems: _____
Male/Female: _____	Age: _____	Health problems: _____
Male/Female: _____	Age: _____	Health problems: _____

Are there any particular illnesses and/or allergies in the family e.g. heart disease, diabetes, asthma, eczema, hay fever, food allergies etc? _____

HOME LIFE:

Who lives at home with the child?

Is your child part of a stepfamily? YES/NO

Does your child have access visits to a parent? YES/NO

Does your child have home tutoring? YES/NO

Does your child attend (please tick): DAY NURSERY CHILD MINDER PLAYGROUP SCHOOL

Please detail if there are any pets at home: _____

Please sign below to confirm that:

- The medical and other information given in this form is accurate to the best of your knowledge.
- You understand that as a nutritional therapist I am not able to diagnose or treat medical conditions, and that nutritional advice is not intended to replace the advice of a medical doctor or substitute professional medical treatment.
- You understand that good nutrition helps to build the body's natural strength and resistance and no claim is made to the certain efficacy of any dietary protocols.

Signature: _____

Date: _____

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PREGNANCY DETAILS

Previous pregnancies including any miscarriages or neo-natal death: _____

Contraceptive history e.g. the pill, coil, implants etc: _____

When last used and for how long? _____

Did you follow a pre-conceptual programme (e.g. Foresight) to optimise health? YES/NO _____

Did you conceive the child naturally? YES/NO Did you receive any fertility treatment prior to conceiving? YES/NO

Please detail: _____

Did you experience any of the following complications in pregnancy?

Bleeding YES/NO Thrush YES/NO Gestational diabetes YES/NO

Nausea/morning sickness YES/NO Cystitis YES/NO High blood pressure YES/NO

Excessive itching YES/NO Excessive water retention YES/NO Pre-eclampsia/PIH YES/NO

Did you receive any treatments for any of the above? YES/NO If yes, what treatments and for which condition? _____

Did you suffer any illnesses during pregnancy, e.g. viruses, operations etc? _____

Please detail any medical tests during pregnancy e.g. how many scans, blood tests etc. and at what stage? _____

Did you take any of the following? Please state how much and at what stage in pregnancy:

Cigarettes YES/NO

Alcohol YES/NO

Tea, coffee, cola YES/NO

Recreational drugs YES/NO

Prescribed medication (e.g. antibiotics, anti-depressants, anti-nausea) YES/NO

Over-the-counter drugs YES/NO

Nutritional supplements YES/NO

Did you suffer any food (or non-food) cravings or aversions during the pregnancy? _____

Did you exclude any foods? _____

Did you lose or gain excessive weight? _____

Did you travel abroad much prior to or during the pregnancy? _____

Did you suffer from any thrush/cystitis or other infections after the delivery? YES/NO How were these treated? _____

BIRTH DETAILS

Duration of pregnancy (normal gestation 40 weeks): _____ Medications e.g. gas & air, epidural, pethedine: _____

Was labour induced? _____

Length of labour: _____ APGAR score: _____ Did your baby suffer JAUNDICE OXYGEN DEFICIT

Birth weight: _____ Birth length: _____ Centile on growth chart e.g. 50th, 25th etc. _____

Type of birth: NORMAL VAGINAL DELIVERY FORCEPS OR VENTOUSE CAESARIAN

Place of birth: HOSPITAL HOME BIRTH CENTRE OTHER _____

Did your baby require special care? YES/NO Why/duration: _____

Additional information about labour/birth: _____

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CHILD'S HEALTH PROFILE

MEDICAL HISTORY

Has your child suffered infections requiring antibiotics? YES/NO If yes, please give age, illness & treatment:

Does/has your child take/taken any other prescribed medications? YES/NO If yes, please give age, illness & treatment:

Does your child take over-the-counter medications? YES/NO If yes, which and what for e.g. Calpol or Antihistamines

Has your child ever been referred to a specialist? YES/NO If yes, please give age, reason and type of specialist:

What tests has your child had by GP, specialist, other? _____

Has your child received a medical diagnosis of any kind? YES/NO If yes, please expand (e.g. asthma, celiac disease etc.)

Any other medical information? _____

DEVELOPMENTAL HISTORY

Has your GP or health visitor ever expressed concern regarding your child's development? YES/NO

If yes, please detail: _____

Has your child's growth pattern been normal e.g. height, weight, growth centile? YES/NO

If no, please detail: _____

IMMUNISATION PROGRAMME

Has your child received the recommended standard immunisations? YES/NO

If no, please detail those given and those excluded and why: _____

Has your child ever had an adverse reaction to a vaccine? YES/NO If yes, please expand: _____

Has your child ever had any of the following infectious diseases?

Whooping cough Measles Mumps Rubella Scarletina Herpes

ACTIVITY PROFILE

How much time per day does your child watch TV? _____

How much time per day does your child use a computer (including school and home)? _____

How much exercise does your child have in a week? _____

What sport does he/she play? _____

Any active hobbies/clubs (e.g. dancing)? _____

POLLUTION PROFILE

Does your child live in a city or by a busy road? YES/NO Is the main home near to: Pylons Petrol Station

Mobile Phone Mast Factory Agricultural Land Flight Path

Does your child live in a smoky atmosphere? _____

Does your child usually drink filtered or bottled water? _____

Does your child eat non-organic foods? _____

Does your child have a TV or computer in their bedroom? _____

Does your child have a mobile phone which is used regularly? _____

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SYMPTOM ANALYSIS - Below is a list of symptoms associated with nutritional deficiencies. Please circle all symptoms that apply now, and underline any that previously applied, each time they occur:

Poor eyesight
Rashes
Mouth ulcers
Diarrhoea
Conjunctivitis/sticky eyes
Thrush
Chest or urinary infections
Dry, flaky skin
Frequent colds/infections
Nose bleeds

Near sightedness
Tooth decay
Muscle cramps/pain
Sweaty
Sore joints
Excessive tiredness
Thin hair/hair loss
Chilblains
Dry skin

Rashes
Easy bruising
Slow wound healing
Weak muscles
Fatigue on exertion
Nappy rash

Rashes
Red pimples on skin e.g. upper arms
Easy bruising
Slow wound healing
Nose bleeds
Frequent colds
Frequent infections
Bleeding gums
Lack of energy

Sore eyes
Irritability
Sore muscles
Poor memory/concentration
Tummy aches
Constipation
Regular pins and needles
Lack of energy

Fatigue
Eye problems
Bed wetting
Dry, itchy skin
Poor hair condition
Slow learning
Sore lips
Eczema dermatitis
Tendency to allergies

Tendency to allergies
Lack of energy
Diarrhoea
Poor sleeper
Poor memory
Easily distracted
Headaches or migraine
Irritability
Bleeding gums
Tendency to depression

Muscle tremors
Lethargy
Bedwetting
Short attention span
Lack of energy
Loss of appetite
Grinds teeth
Anxiety or tension
Nausea or vomiting
Insomnia

Nausea
Learning difficulties
Swollen ankles or hands
Muscle pains
Nervous or depressed
Fits/convulsions
Pins and needles
Fatigue
Irritability

Slow growth
Poor hair condition
Eczema/dermatitis
Anxiety/tension/irritability
Lack of energy
Constipation
Pale skin
Loss of appetite

Fatigue
Insomnia
Poor memory
Breathlessness
Irritability
Eczema
Tummy ache
Sore lips
Poor appetite
Anxiety

Dry skin
Poor hair condition
Nausea/lack of appetite
Eczema/dermatitis
Drowsiness
Diarrhoea
Muscle pains
Fatigue

Frequent infections
Excessive thirst
Rashes
Dry skin
Eczema
Nappy rash
Sore eyes
Poor wound healing

Muscle cramps/twitches
Insomnia
Tooth decay
Joint pains
Brittle nails
Nervousness
Bedwetting

Learning difficulties
Poor sleep
Anxiety
Colic
Hyperactivity
Fits or convulsions
Constipation
Muscle weakness
Bed wetting

Pale skin
Lack of energy/lethargy
Nausea
Loss of appetite
Slow growth
Headaches
Slow learning

Rashes
Poor appetite
Slow growth
White spots on nails
Slow wound healing
Pale skin
Prefers strong, salty flavours
Moody
Frequent infections
Nausea

Growing pains
Sore knees
Fits or convulsions
Dizziness
Diabetes
Dermatitis
Slow growth
Learning difficulties

Poor growth
Family history of cancer
Visual defects
Frequent infections
Skin disorders

Addicted to sweet foods
Depression
Irritability
Needs frequent meals
Drowsiness
Learning problems
Thirst
Sweaty
Dizziness

CHILD NUTRITIONAL THERAPY QUESTIONNAIRE

MISCELLANEOUS SYMPTOMS

Please circle all symptoms that apply now, and underline any that previously applied:

Earache	Poor co-ordination	Obsessive behaviour
Catarrh	Head banging/rocking	Mood swings
Colic	Sensitivity to noise	Thrush
Excessive crying	Phobias	Night terrors
Aggression	Shows no fear	Disturbed sleep
Constant runny nose	Recurrent chest infections	
Snoring	Threadworms	

DIGESTIVE PROFILE

Does your child chew food well? YES/NO Does your child suffer from bad breath? YES/NO
Does your child suffer from tummy upsets? YES/NO Does your child suffer from an itchy bottom? YES/NO
Does your child suffer from diarrhoea? YES/NO Does your child have a daily bowel movement? YES/NO
Does your child suffer from constipation? YES/NO Does your child suffer from bloating/excessive wind? YES/NO
Are the stools normal, pale, offensive, floating? (Please underline which)
Does your child suffer from any food sensitivities? _____

CHILD'S FEEDING HISTORY AND EATING HABITS

Did you breast feed at all? YES/NO For how long? _____
Did you require any medications whilst breastfeeding? _____
Did you formula feed at all? YES/NO From what age? _____ Which formula? _____
How old was your baby when you started weaning onto solids? _____
Which foods were introduced and in what order?

1. _____ Age? _____ Any reactions: _____
2. _____ Age? _____ Any reactions: _____
3. _____ Age? _____ Any reactions: _____

At what age did you introduce the following?

Wheat _____ Any reactions? _____
Whole cow's milk _____ Any reactions? _____
Egg _____ Any reactions? _____
Peanuts _____ Any reactions? _____
Citrus fruits _____ Any reactions? _____

Did you offer any ready-made baby foods? YES/NO Which ones and at what age? _____

Is your child a fussy eater? YES/NO Is your child's appetite GOOD MEDIUM POOR Do you avoid giving foods that contain sugar? YES/NO
Do you avoid giving foods containing E-numbers? YES/NO
Are there any foods your child craves? _____ Does your child eat at nursery/school YES/NO If yes, please describe this food/drink: _____
Are there any foods your child dislikes intensely? _____ Does your child take a lunch box? YES/NO
Please circle any of the following ways you prepare food:
Who does the shopping/cooking? _____ GRILL BAKE FRY STIR FRY MICROWAVE BOIL RAW
Do you normally eat white or wholemeal rice, pasta and flour? _____
How many times a week does your child have meals containing fried or fast foods e.g. fish fingers, McDonalds? _____
How many portions of fruit a day? _____ How many portions of vegetables a day? _____
How many cans of fizzy drink a week? _____ How many slices of bread or rolls a week? _____

FOOD DIARY Key: S = School; H = Home; N = Nursery

HOW TO COMPLETE

1. Choose four normal/average days; including at least one home or rest day and one school/nursery day.
2. Please list all foods and fluids your child consumes throughout the day including snacks.
3. It is important to give as much detail as possible to show quantity e.g.
 - Teaspoons, tablespoons, cups or pints, can/tin size
 - Brand names or ingredients of composite meals (or cut out and include the ingredients list)
 - Type of milk used
 - Fried, steamed, boiled, roasted, fresh, frozen, canned or dried food
4. Please return your completed questionnaire and food to my clinic address to arrive at least four working days before your child's initial consultation. If you have any queries please call me on 01730 810008.

DAY/DATE:	Approx times	S	H	N
Breakfast:				
Lunch:				
Dinner:				
Snacks:				
Drinks:				

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Breakfast:				
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