



Nutrition Client Intake Form Child/Teen

Please answer the following questions as thoroughly as possible. Leave blank if they do not apply. This will help me support your child's needs to the best of my abilities.

Date

Personal Information:

Client's Full Name	Nickname	Date of Birth
Parent(s) Name(s)	Sibling's? Ages?	
Address	City	State
Home Phone	Mobile Phone (parent)	Mobile Phone (teen)
Email (parent)	Email (teen)	

Weight History:

Height	Current Weight	Do you feel healthy at this weight? <input type="checkbox"/> Yes <input type="checkbox"/> No
Describe your weight history. Any fluctuations? Any past diets—successful or not?		
Have you previously made any nutritional changes to alter your weight? When, what, why and per whose recommendation?		

Lifestyle:

Grade in school?	Sports or extracurricular activities?		
Any family members with special needs? If so, please describe:			
Rate your average stress level <input type="checkbox"/> low <input type="checkbox"/> average <input type="checkbox"/> high <input type="checkbox"/> very high	What is the primary cause of your stress?	What do you do to relieve stress?	
Have you had any accidents or traumatic life events in the past 10 years? If so, please explain:			
What type of physical activity do you do?	Typical duration per time?	Intensity (low, moderate, high)	Any other movement throughout your day?
Average hours of sleep per night?	Do you have difficulty falling asleep?	Do you have wakefulness at night?	



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Food and Eating:

Do you eat on a regular schedule most days?	How often does your family cook at home?	Who plans / shops for / cooks meals?
How often do you eat out?	Describe your favorite restaurant and meal out:	
How many 8 oz. glasses of water do you drink in a typical day?	What are your 5 favorite foods?	
How often do you eat in front of the TV?	What are your bad habits around eating?	

Food Frequency:

How often do you eat the following foods? Check the appropriate box next to each food:

	Daily	2-4 times a week	Once a week	Once a month	Never		Daily	2-4 times a week	Once a week	Once a month	Never
Fruit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Butter	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vegetables	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Olive Oil	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tofu - Tempeh - Miso	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Snack / Junk Food	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other Soy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	White Bread	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nuts / Seeds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fried Foods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nut Butters	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Desserts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Beans / Legumes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Candy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dairy Products	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Soda	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Whole Grains	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sport Drinks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fish	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Red Meat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Coffee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Poultry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eggs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Artificial Sweeteners	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Margarine - Vegetable Oil	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fast Food	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Digestion and Elimination:

How often are you gassy/bloated after a meal?	How often do you have heartburn or reflux?	How soon after eating do you feel hungry again?
How many bowel movements do you have per day/week?	How often do you have constipation or hard, dry stools?	How often do you have diarrhea?



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Medical History:

Current or previous conditions:		
<input type="checkbox"/> Diabetes (type) _____	<input type="checkbox"/> Allergies (list) _____	<input type="checkbox"/> Other (please describe) _____
<input type="checkbox"/> Chronic fatigue _____	_____	_____
<input type="checkbox"/> Eczema _____	_____	_____
<input type="checkbox"/> Anemia _____	_____	_____
<input type="checkbox"/> PMS / Menstrual irregularity _____	_____	_____
<input type="checkbox"/> Thyroid disorder (type) _____	_____	_____
<input type="checkbox"/> Migraines _____	_____	_____
<input type="checkbox"/> Asthma _____	_____	_____
<input type="checkbox"/> Celiac disease _____	<input type="checkbox"/> Food sensitivities (list) _____	_____
<input type="checkbox"/> Hypoglycemia / Low blood sugar _____	_____	_____
<input type="checkbox"/> Chronic constipation _____	_____	_____
<input type="checkbox"/> Blood clotting problems _____	_____	_____
<input type="checkbox"/> Colitis _____	_____	_____
<input type="checkbox"/> Eating disorder (type) _____	_____	_____
Do you frequently experience:		
<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Hay fever	<input type="checkbox"/> Hives / Rashes
<input type="checkbox"/> Constipation	<input type="checkbox"/> Mood swings	<input type="checkbox"/> Dental cavities
<input type="checkbox"/> Bloating / Gas	<input type="checkbox"/> Attention / Focus problems	<input type="checkbox"/> Chemical sensitivities
<input type="checkbox"/> Heartburn / Reflux	<input type="checkbox"/> Bleeding gums	<input type="checkbox"/> Acne / Boils
<input type="checkbox"/> Nausea	<input type="checkbox"/> Easy bruising	<input type="checkbox"/> Muscle cramps
<input type="checkbox"/> Colds / Flu	<input type="checkbox"/> Brittle nails	<input type="checkbox"/> Joint pain / Stiffness
<input type="checkbox"/> Sinus problems	<input type="checkbox"/> Dry skin / Lips	<input type="checkbox"/> Memory problems
<input type="checkbox"/> Headaches	<input type="checkbox"/> Vomiting (with nausea)	<input type="checkbox"/> Infections: type _____
What are your known medical conditions?		
Did you have any significant illnesses in infancy or childhood?		
How frequently have you taken antibiotics in the past 2 years?		
What prescription medications do you currently take?		
What vitamins or other supplements do you currently take?		
Describe any health (physical or emotional) symptoms that currently bother you. How long have they been a problem?		