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	Zip
Home Phone	Mobile Phone (parent)	Mobile Phone (teen)	
Email (parent)	Email (teen)		

Weight History:

Height	Current Weight	Do you feel healthy at this weight? ☐ Yes ☐ 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 ☐ low ☐ average ☐ high ☐ 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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A HEALTHY LIFE
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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
Fruit	☐	☐	☐	☐	☐
Vegetables	☐	☐	☐	☐	☐
Tofu - Tempeh - Miso	☐	☐	☐	☐	☐
Other Soy	☐	☐	☐	☐	☐
Nuts / Seeds	☐	☐	☐	☐	☐
Nut Butters	☐	☐	☐	☐	☐
Beans / Legumes	☐	☐	☐	☐	☐
Dairy Products	☐	☐	☐	☐	☐
Whole Grains	☐	☐	☐	☐	☐
Fish	☐	☐	☐	☐	☐
Red Meat	☐	☐	☐	☐	☐
Poultry	☐	☐	☐	☐	☐
Eggs	☐	☐	☐	☐	☐
Margarine - Vegetable Oil	☐	☐	☐	☐	☐

	Daily	2-4 times a week	Once a week	Once a month	Never
Butter	☐	☐	☐	☐	☐
Olive Oil	☐	☐	☐	☐	☐
Snack / Junk Food	☐	☐	☐	☐	☐
White Bread	☐	☐	☐	☐	☐
Fried Foods	☐	☐	☐	☐	☐
Desserts	☐	☐	☐	☐	☐
Candy	☐	☐	☐	☐	☐
Soda	☐	☐	☐	☐	☐
Sport Drinks	☐	☐	☐	☐	☐
Alcohol	☐	☐	☐	☐	☐
Coffee	☐	☐	☐	☐	☐
Tea	☐	☐	☐	☐	☐
Artificial Sweeteners	☐	☐	☐	☐	☐
Fast Food	☐	☐	☐	☐	☐

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:

- ☐ Diabetes (type) _____
- ☐ Chronic fatigue
- ☐ Eczema
- ☐ Anemia
- ☐ PMS / Menstrual irregularity
- ☐ Thyroid disorder (type) _____
- ☐ Migraines
- ☐ Asthma
- ☐ Celiac disease
- ☐ Hypoglycemia / Low blood sugar
- ☐ Chronic constipation
- ☐ Blood clotting problems
- ☐ Colitis
- ☐ Eating disorder (type) _____
- ☐ Allergies (list)
- ☐ Food sensitivities (list)
- ☐ Other (please describe)

Do you frequently experience:

- ☐ Diarrhea
- ☐ Constipation
- ☐ Bloating / Gas
- ☐ Heartburn / Reflux
- ☐ Nausea
- ☐ Colds / Flu
- ☐ Sinus problems
- ☐ Headaches
- ☐ Hay fever
- ☐ Mood swings
- ☐ Attention / Focus problems
- ☐ Bleeding gums
- ☐ Easy bruising
- ☐ Brittle nails
- ☐ Dry skin / Lips
- ☐ Vomiting (with nausea)
- ☐ Hives / Rashes
- ☐ Dental cavities
- ☐ Chemical sensitivities
- ☐ Acne / Boils
- ☐ Muscle cramps
- ☐ Joint pain / Stiffness
- ☐ Memory problems
- ☐ 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?

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