

Kathy McCune, RD MA

Nutrition Questionnaire (Child)

Today's Date: \_\_\_\_\_

Child's Name: \_\_\_\_\_ Sex: Male/Female

Birthdate: \_\_\_\_\_

**The following questions will help me learn more about your child's nutritional health.**

*Please answer each of these questions: (circle the appropriate response)*

- 1) How does your child appear to you: \_\_\_\_\_ Overweight/Underweight/Just Right/Short
- 2) Is your child now on a special diet? \_\_\_\_\_ Yes/No  
If yes, what kind? \_\_\_\_\_
- 3) Is your child now allergic to or intolerant of any foods? \_\_\_\_\_ Yes/No  
If yes, what foods? \_\_\_\_\_
- 4) Is your child now a "picky" eater? \_\_\_\_\_ Yes/No  
If yes, circle all that apply:  
Refuses many foods      Has a poor appetite      Thinks foods are "good" or "bad"  
Other: \_\_\_\_\_
- 5) Does your child now take any medications? \_\_\_\_\_ Yes/No  
If yes, what medication(s)? \_\_\_\_\_
- 6) Does your child now take vitamins/minerals? \_\_\_\_\_ Yes/No  
If yes, name of supplement and dose: \_\_\_\_\_
- 7) Does your child have either of the following: Diarrhea      Constipation
- 8) Does anyone in your family have or ever had heart disease? \_\_\_\_\_ Yes/No
- 9) Does your child eat when he/she is stressed or upset? \_\_\_\_\_ Yes/No
- 10) Does your child have dental problems? \_\_\_\_\_ Yes/No
- 11) Is your child able to participate in physical activity? \_\_\_\_\_ Yes/No  
If yes, what type of activity and how often: \_\_\_\_\_
- 12) How many hours of television does your child watch per day? \_\_\_\_\_
- 13) Do you have any additional concerns about your child's growth, nutrition or eating?  
\_\_\_\_\_  
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