



Community Nutrition Services Pediatric Background Questionnaire

Date: _____

Name: _____ Parent's name: _____

Phone Number(s): Home: _____ Alternate: _____ work/cell

Physician(s): _____

1. Age: _____ Date of Birth: ____/____/____ Ht: _____' _____" Wt: _____

2. Grade in School : _____

4. Personal and Family Medical History:

Please place a (X) in column A if you currently have or have had any of the following health problems. Please place a (X) in column B if any members of your immediate family (i.e.: parents, siblings, or grandparents) have or had any of the following conditions:

	A. Yourself	B. Family
1. Overweight		
2. Diabetes		
3. Hypoglycemia (Low Blood Sugar)		
4. High Blood Pressure		
5. High Cholesterol		
6. Heart Attack		
7. Stroke		
8. Bypass Surgery		
9. Angina		
10. Cancer		
11. HIV		
12. Kidney Disease		
13. Psychiatric History		
14. Orthopedic Problem (Knees & Joints)		
15. Other (Please Specify):		

5. Living Situation: (Please circle all that apply)

Both Parents / Joint Custody / Mother / Father / Other: _____

6. Who does the cooking in your household? _____

7. Who does the grocery shopping in your household? _____

8. How is food typically prepared? (Please circle all that apply)

Baked / Fried / Microwaved / Grilled / Other(s): _____

9. How often, and at which meals, do you eat out during the week?
Breakfast _____ / Lunch _____ / Dinner _____ / Others _____
10. What types of restaurants do you usually frequent? (Please circle all that apply)
Fast Food / Salad Bar-Buffets / Ethnic Foods / Others _____
11. How many teeth do you have? (If age 2 or under) _____
12. Do you have difficulty chewing or swallowing food? Yes ___ No ___
13. Do you do any regular physical exercise? Yes ___ No ___ If yes, what type? _____
How often? _____
14. Have you had any previous nutritional counseling? Yes ___ No ___
15. Are there any foods you avoid for religious, health, or philosophical reasons?
Yes ___ No ___
If yes, explain: _____
16. Do you have any food allergies or intolerances? Yes ___ No ___
If yes, explain: _____
17. How is your appetite? Good / Fair / Poor
18. Have you made any significant changes in your eating recently? Yes ___ No ___
If yes, explain: _____
19. Do you take vitamins, minerals, herbal, or nutritional supplements? Yes ___ No ___
If yes, please list: _____
20. Are you currently taking prescription medication? Yes ___ No ___
If yes, please list: _____
21. Has your weight changed over the past year? Yes ___ No ___
If yes, how many pounds have you gained? _____ lost? _____
Describe any significant events in your life which influenced this: _____

Continue with following questions if you are 11 years old or older

22. Do you smoke? Yes _____ No _____ (Quit _____ Month _____ Year _____)
23. Do you drink alcohol? Yes _____ No _____
If yes, what type? _____ How often? _____

If weight control is a concern for you, answer 22 - 24

24. At what weight have you felt you best, or think you would feel your best? _____

25. Have you been on weight loss diets before? Yes _____ No _____
 If yes, explain: _____

26. What significant problem, if any, have you encountered with previous weight loss efforts?

INDICATE BELOW WHAT YOU EAT IN A TYPICAL DAY AND WHEN. INCLUDE MEALS, SNACKS, BEVERAGES, ETC.	
BREAKFAST TIME:	
SNACK: TIME:	
LUNCH TIME:	
SNACK TIME:	
DINNER TIME:	
SNACK TIME:	