BETTER LIVING Nutrition

...Caring for the whole you

Pediatric Questionnaire

Thank you for taking the time to invest in your child's health and wellbeing.

Holistic nutrition is a rapidly growing area of healthcare that is based on the principles of balancing and harmonizing the whole body. This is done through diet and lifestyle changes specific to your child.

Note: All the information gathered is completely confidential and will not be shared with any third parties.

Please be as candid and open as possible the get the most out of your session.

CHILD'S INFORMATION

Child's Name _____ Date of birth _____ _____ _____ Age_____
mm dd yyyy

Sex: M F

Mother's Name:_____ Father's Name:_____

Primary phone _____ Email address _____

Cell phone _____ Work Phone _____

Emergency Contact _____ Phone (for emergency) _____

Please enter your address:

No. & Street _____ Apt #, Unit #, PO Box # _____

City, Town _____ Province, State _____

Postal code _____ Country _____

Name of Child's Physician:_____

Physicians Phone No: _____

MAIN HEALTH CONCERNS

Reason(s) for visit today?

_____

_____

_____

MEDICATIONS

NOW	PAST		NOW	PAST	
_____	_____	Aspirin	_____	_____	Decongestants
_____	_____	Tylenol	_____	_____	Anti-histamine
_____	_____	Antibiotics	_____	_____	Other_____
_____	_____	Ibuprofen	Allergies to medicines:_____		

MEDICAL HISTORY

_____ Chicken pox _____ Scarlet fever _____ Tonsillitis, no. times: _____

_____ Measles _____ Pneumonia _____ Ear infections, no .times _____

_____ Mumps _____Frequent cold _____ Strep throat, no times _____

_____ Rubella _____Rheumatic fever Other_____

Has your child ever had any of the following: WHEN WHERE RESULTS

Electroencephalogram (EEG):_____

Psychological evaluations:_____

Hearing Test:_____

Speech/language tests: _____

Injuries/surgeries/hospitalizations (please list)_____

_____

IMMUNIZATIONS

☐ My child has not received any immunizations

_____ MMR _____ DPT _____Chicken pox Others:_____

_____ Measles _____ Diphtheria _____ Small pox Adverse Reactions: Y / N

_____ Tetanus _____ Strep _____ H. influenza If so, what?_____

_____ Rubella _____ Polio _____ The flu _____

FAMILY MEDICAL HISTORY (Please circle if parents, grandparents or siblings had these and list who)

Heart disease	Diabetes	Birth defects
Hypertension	Arthritis	Tuberculosis
Cancer	Allergies	Asthma
Mental illness	Osteoporosis	Other significant:

PRENATAL HISTORY

Previous pregnancies by natural mother, miscarriages, or complications?_____

_____

Mother's age at child's birth:_____

Mother's health during pregnancy (please circle):

Bleeding	Nausea	Physical or emotional trauma
Illnesses	Hypertension	Cigarettes, alcohol, drug consumptions
Medications (which)_____	Diabetes	Thyroid problems

BIRTH HISTORY

Term: _____ Full _____ Premature _____ Late Weight at birth:_____

Length of labor: _____ Complications: _____

Did your child have any of the following problems shortly after birth (please circle)?

Rashes	Birth injuries	Blue baby
Jaundice	Seizures	Cerebral palsy
Colic	Fever	Birth defects

Other: _____

Child's sleep patterns (1st year): _____

Food Intolerances_____

Breast fed: Y / N How long: _____ Formula: Y / N Type (milk/soy):_____

Age began solids:_____ Which foods were first introduced?_____

Age began: Sitting_____ Crawling_____ Walking_____ Talking_____

SYMPTOMS: Check all that apply

_____Hives	_____Burning urine	_____Bloody urine	_____Eczema	_____Cries easily
_____Bleeding gums	_____Heart murmur	_____Nervous	_____Asthma	_____Vomiting spells
_____Sleep problems	_____Acne	_____Anemia	_____High fever	_____Night sweats
_____Nose bleeds	_____Jaundice	_____Chronic rash	_____Cough	_____Colic
_____Stomach aches	_____Hearing loss	_____Sore throats	_____Flat feet	_____Easy bruising
_____Frequent colds	_____Hair loss	_____Joint pains	_____Wheezing	_____ Dizzy spells
_____Diarrhea	_____Nightmares	_____Bed Wetting	_____Allergies	
_____Night mares	_____Constipation	_____Allergies	_____Sensitive to light	
_____Bleeding easily	_____Frequent urination		_____No Appetite	
_____Unusual fears	_____Excessive fatigue		_____Body/breath odor	

How would you describe your child's appetite? ☐ Hearty ☐ Moderate ☐ Poor

Does your child have difficulty chewing, swallowing or digesting food? ☐ Yes ☐ No

Does your child eat at approximately the same time every day? ☐ Yes ☐ No ☐ Sometimes

How many **meals** does our child have each day? _____

How many **snacks** does your child have each day? _____

During one week, where does your child eat most of his/her food? ☐ Home ☐ School ☐ Restaurant ☐ Babysitter/Daycare ☐ Other_____

Was your child bottle fed or breast fed?_____ To what age?_____

Is there any food your child cannot eat or drink? Yes No If yes, what foods?_____

Is your child allergic to any foods? Yes No If yes, what foods?_____

Is your child on a special diet? (e.g. Diabetic; Vegetarian, etc.) ☐ Yes ☐ No

Specify type of diet_____ Who recommended it?_____

Has your child been on any special diets in the past? ☐ Yes ☐ No What kind?_____

How many servings of fruits does your child eat/drink each day?_____ Vegetables_____

Please list kinds of fruits/vegetables most eaten_____

How much of the following drinks does your child have each day? Milk_____ What kind?_____

Kool-Aid_____ Juice_____ Soda_____ Sports drinks_____ Tea/coffee_____ Other_____

How long does it usually take your child to eat? _____

Would you describe your child as a fussy eater? ☐ Yes ☐ No

How many bowel movements does your child have each day?_____

Is this bowel movement loose, formed, hard, etc. Please describe_____

Please describe what your child usually eats for breakfast, lunch, dinner and snacks.

Meal	Food/Method of Preparation	Amount Eaten
Breakfast		
Snack		
Lunch		
Snack		
Supper		

Please list any food aversions and/or foods your child dislikes:

_____

_____

_____

Does your child sit in front of the TV or computer

While eating? ☐ Yes ☐ No

List the top 5 foods you eat the most often.

1 _____ 4 _____

2 _____ 5 _____

3 _____

How would you describe your child's energy level?

_____

How would you describe your child's temperament?

_____Irritable or Touchy _____Easy going and a people person

_____Nervous _____Bossy

What is your child's current weight?_____ Height_____

How do you feel about your child's weight right now? ☐ Too Heavy ☐ Too Thin

What is your child's growth pattern in the past year? Please describe_____

Has your child used any weight loss programs in the past? ☐ Yes ☐ No

If yes, please describe_____

Does your child vomit or have diarrhea to keep her/his weight down? ☐ Yes ☐ No

☐ Every day ☐ 3-4 times/week ☐ Never ☐ Sometimes

What does your child do for exercise?_____

How much "Screen Time" does your child do in a day?(phone, TV, computer, X-box etc.)_____

How much time does your child spend playing outside during the day?_____

What time does your child go to bed each night?_____

How many hours does your child sleep_____ Do your child seem rested?_____

How many glasses of water does your child drink a day? _____

What is your source of water? Please circle all that apply: (8 oz.)

Filtered Tap Reverse Osmosis Spring Bottled Other _____

YOUR CHILD'S EMOTIONAL HEALTH

Has there been any significant emotional trauma in your child's life? Divorce, separation, family problems, death of someone close, abuse, etc.
Please describe.

Does your child often have nightmares? Yes ☐ No ☐

Does your child have fears that they express to you? Yes ☐ No ☐

Please Describe:

YOUR CHILD'S ENVIRONMENTAL HEALTH

Please circle all that apply:

Use chlorinated bleach	Bathe or Shower in Chlorinated water	Eat food from tin cans
Nail Polish	Regular laundry soap	Air Fresheners in home
Regular body or hand lotions	Nail Polish Remover	Cosmetics
Dryer sheets	Insecticides used in or around home	Pesticides
Food heated in microwave	Food wrapped in tin foil	Plastic wrap
Aluminum cookware used	Plastic ware heated in Microwave	Gas stove in kitchen
Fresh or salt water fish/shellfish	Consume organ meats	Artificial sweeteners
Cell phone use	Live near high power lines	Electric blanket use
	Computer use	Garage attached to house

BETTER LIVING Nutrition

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Service agreement

This agreement is between, GLENDA NISCHUK, OWNER OF BETTER LIVING NUTRITION and

_____ _____

Child's Name Parent/Guardian's Name

Terms & Conditions

ACCEPTANCE OF SERVICES

I take full responsibility for my child's health, healing and progress on his/her nutrition plan. I acknowledge change can take time and I am ready for a plan that is not about fad diets or quick-fixes but about smaller changes over time leading to sustainable change.

CONFIDENTIALITY

All information shared within the professional relationship will be held with the strictest confidence. We will only share your information at your request and with your consent. Storage, retention and destruction of your personal information complies with existing legislation, and privacy protocols.

SCHEDULING & CENCELLATION

Please do everything possible to keep your appointment as this time is reserved just for your child. If you are unable to keep your appointment, please give us at least 24 hours notice so we may schedule another time for you. Thank-you.
Please note: Habitually missed appointments with no notification will be billed in full.

PAYMENT POLICY

Payments are due in full upon receipt of invoice and/or after session. Payment can be made via cash,
Debit, Visa, Master card or cheque made payable to Better Living Nutrition.

☐ *By submitting this form to Better Living Nutrition,*
I fully understand and agree with the terms and conditions outlines above.

Date _____ _____ _____

mm dd yyyy

THANK YOU FOR TAKING THE TIME TO COMPLETE THIS QUESTIONNAIRE

I look forward to helping your child achieve their finest health ever!

Glenda Nischuk Holistic Nutritionist RNCP betterliving2@sasktel.net nutrition.betterlivingcentre.ca