



Pediatric Nutrition / Functional Medicine Assessment

Child's Name: _____ **Birthdate / age:** _____ **Today's date:** _____

Parent / Guardian: _____

Address: _____ **City:** _____ **Zip:** _____

Emergency Contact: _____ **Relation:** _____ **Phone:** _____

Main reason for consultation: _____

What goals would you like your child to accomplish through nutritional counseling and / or functional medicine?

1). _____

2). _____

3). _____

List medications / supplements: _____

Allergies (food / medications) _____

Past medical history (dates)

Birth: Vaginal : C-Section : Premature : Complications: _____

Vaccinations: Complete childhood Partial Vaccinations None

Vaccine Reactions: _____

Serious Illnesses / Trauma: _____

Dietary Patterns:

Breastfed _____ # of months. Bottle fed Supplemental - Formula type _____

Childhood diet: American Vegetarian Gluten Free Dairy Free

Specialty diet _____

How many meals and snacks does your child eat per day? _____ (attach diet record)

Percent of meals eaten at home _____%

Does your household use a microwave? Yes No

Percent of organic / locally grown food _____%

What type of salt and sweetener does your family use? _____

Is your child a picky eater? Yes No

Does your child have any specific cravings? List _____

Weight History

Current weight _____ lbs. Height ____ft ____inches

Any concerns regarding growth?

Exercise:

Is your child active / exercise on a consistent basis? Yes No

Check all that apply: Running / Jogging Biking Swimming Team sports

Other: _____

Beverages:

Type of water: City Bottled Reverse Osmosis Well Other _____

Amount of water per day: _____ cups / 8 oz servings

Sodas: _____ per day Juice: _____ per day Other beverages: List _____

Head / Neck:

Headaches Yes No If yes, list contributing factors: _____

Dental issues: Cavities, bleeding gums, orthodontics: Yes No

Any constant coating on tongue? Yes No If yes color _____

Allergies / Post nasal drip Yes No Type: _____

Frequent colds / sinus / ear / infections Yes No History of strep throat Yes No

Cardiovascular / Lungs:

Bronchitis / Pneumonia Yes No Asthma Yes No

Complains of his/ her heart pounding or chest hurting: Yes No

Has your child ever been on steroid inhalers? Yes No

Digestion:

Check all that apply:

Bloating Acid Reflux / Heartburn Abdominal Pain Excessive Gas

Bowel movements: frequency < 1 per day daily 2-3 per day + 3 per day

Consistency of bowel movements: Loose Normal Hard Combination

Anemia Yes No Blood in stool: Yes No

Does your child take laxatives or fiber on a consistent basis? Yes No

History of inflammatory bowel disease? Yes No

Has your child ever been on an acid blocker? Yes No

Musculoskeletal:

Joint Pain: Yes No If yes, location / duration: _____

Scoliosis Foot / back trouble Growing pains

Is your child under the care of a chiropractor Yes No Name of D.C. _____

Condition of Nails: Brittle Curved White spots Ridged

Skin:

Acne Eczema Psoriasis General rashes

Age of Onset and Treatments: _____

History of Tick Bite: _____

Endocrine / Sleep:

Is your child or a family member a diabetic? Yes No

If yes; what relation of family member and age of dx _____

Insulin dependent: Yes No Oral anti-diabetic meds, list _____

How many hours of sleep does your child average per night? _____

Insomnia Yes No If yes, explain _____ Night terrors Yes No

Does your child complain of being tired? Yes No

Symptoms of early puberty: Yes No If yes, explain: _____

Brain Health:

Lack of attention / focus: Yes No Anxiety: Yes No

Panic Attacks Yes No Hyperactivity: Yes No Seizures (ever): Yes No

ANY head trauma: (list, dates) _____

Environmental Toxins:

Does your family use antibacterial soaps? Yes No

What percent of your household cleaners are natural, "green"? _____%

Is your lawn / garden treated regularly with fertilizers / herbicides / pesticides? Yes No

Has your child been exposed to a moldy environment? Yes No

Is your child sensitive to chemicals / odors? Yes No

Family History / General:

List any significant health issues that run in your family: _____

How would you prefer your child's care be guided? (check all that apply)

- Dietary review, recommendations for healthy choices, general supplements
- Supplement recommendations for specific health conditions, includes muscle testing.
- General blood work analysis, including vitamin D / B 12
- Body chemistry analysis for targeted health conditions (hair / stool / urine analysis)

What percent are you committed to getting well and staying well? _____%

The statements made on this form are accurate to the best of my recollections:

(Signature)

(Date)