Nutrition Questionnaire

2 years to 9 years

Patient Name _____ Today's Date _____

Date of Birth _____ Patient Age _____

Is your child allergic to any food or drinks? O Yes O No

If yes, allergic reaction to what? _____

How do you react? O Rash O Swelling O Itching / Tingling (mouth, throat, ears)

O Difficulty breathing O Vomiting

Does your child take any vitamins/minerals or food supplements? O Yes O No

If yes, which ones? _____

How many days per week does your child eat

Breakfast: _____ Lunch: _____ Dinner: _____ Snacks: _____

Does your child eat out (restaurants, take-out, fast food, etc.)? O Yes O No

How often? _____

List restaurants usually chosen: _____

Does your child take lunch to school or buy lunch at school? _____

Examples of food choices: _____

_____

When does your child usually snack? O Mid-morning O After school O After dinner

Most common food choices for snack: _____

_____

Does your child currently exercise/participate in sports? O Yes O No

How many days per week and minutes per day does your child exercise or play sports?: _____

Types of physical activity most enjoyed?_____

_____