A Look at Your Child's Nutrition

Nutrition Screening Form

Office Use Only ID#_____
Location _____
FRC _____

Today's Date: _____

Child's Name: _____ Age: _____ Birth date: _____ ☐ male ☐ female

Your Name: _____ Phone #: _____ Relationship to child:: _____

Address: _____ City: _____ State: _____ Zip: _____

Birth weight: _____

Was your child premature (born early)? ☐ yes ☐ no (2 pts if < 2 y.o. and LBW or PM) If yes, how many weeks early? _____

Did you breastfeed your child? ☐ yes ☐ no If yes, for how long? _____

The following questions will help us learn more about your child. Please answer each of the following questions.

1. How does your child appear to you?

☐ overweight (3) ☐ underweight (4) ☐ just right ☐ short (2)

If available, what is your child's most recent: weight _____ height _____ date of measurement: _____

2. Do any of the following apply to your child's food intake? ..... ☐ yes (3) ☐ no

If yes, check all that apply.

☐ refuses many foods ☐ drinks more than 40oz. milk per day (5 cups) ☐ eats too much

☐ refuses solid foods ☐ has poor appetite ☐ eats too little

☐ eats fewer than 3 times per day ☐ other: _____

3. Does your child have any feeding or eating problems? ..... ☐ yes (4) ☐ no

If yes, check all that apply.

☐ difficulty sucking ☐ difficulty feeding self ☐ chokes on solids

☐ difficulty chewing foods ☐ chokes on liquids ☐ loses food from mouth

☐ using bottle after age 2 years ☐ difficulty drinking from a cup ☐ takes a long time to eat

☐ other: _____

4. Does your child have a feeding tube? ..... ☐ yes (5) ☐ no

5. Is your child on a special diet for a medical condition (e.g., diabetes, PKU,…)? ☐ yes (4) ☐ no

If yes, what kind? _____

6. Is your child allergic to, or intolerant of, any foods? ..... ☐ yes (2) ☐ no

If yes, what foods? _____

7. Does your child often have diarrhea? ..... ☐ yes (3) ☐ no

8. Does your child often have constipation? ..... ☐ yes (2) ☐ no

9. Does your child often vomit? ..... ☐ yes (3) ☐ no

10. In the past six months was your child found to be anemic (low blood iron)? ..... ☐ yes (2) ☐ no

11. Does your child currently have dental problems? ..... ☐ yes (1) ☐ no

12. Does your child take medications? ..... ☐ yes (2) ☐ no

If yes, what medications and for how long? _____

_____

13. Does your child take vitamins/minerals/home remedies/herbal products? ..... ☐ yes (1) ☐ no

If yes, name of supplement(s)? _____

14. Does your child eat any non-food items (clay, dirt, starch,…) ..... ☐ yes (4) ☐ no

If yes, specify: _____

15. What is your child's activity level?

☐ walks independently ☐ needs help walking (braces/walker) (2)
☐ does not walk ☐ not old enough to walk

16. Do you have trouble buying enough food to feed your family? ..... ☐ yes (3) ☐ no

17. Does your child participate in any of the following programs? Check all that apply.

☐ WIC	☐ SSI	☐ Foster Care	☐ DDD
☐ ITN/CSHCN	☐ Medicaid	☐ School District	☐ Home Health
☐ Early Intervention Provider	☐ Private Insurance	☐ Head Start/Early Head Start	☐ Feeding Clinic
☐ Public Health Nurse	☐ Food Stamps	☐ Other: _____	

18. Do you have any additional concerns about your child's growth, nutrition or eating? .... ☐ yes (1) ☐ no

If yes, what are your concerns? _____

19. Is your child currently receiving nutrition services? ..... ☐ yes ☐ no

If yes, name of person or agency: _____

Child's Ethnicity (check major one):

☐ Caucasian ☐ Hispanic/Latino ☐ American Indian ☐ African American ☐ Asian/Pacific Islander ☐ Other/Unknown ☐ Multi-Racial

Child's Medical Diagnosis (check any which apply):

☐ Asthma/Pulmonary Disease	☐ Autism Spectrum Disorder	☐ Bronchopulmonary Disease (BPD)	☐ Cancer
☐ Congenital heart disease	☐ Cerebral Palsy	☐ Chromosome disorder (i.e., Down Synd.)	☐ Cleft lip/palate
☐ Cystic Fibrosis	☐ Developmental delay	☐ Epilepsy/seizures	☐ Gastrointestinal disorder
☐ Metabolic/endocrine disorders	☐ Muscular Dystrophy	☐ Neurological disorder	☐ Orthopedic problems
☐ Renal (kidney) disease	☐ Sensory impairment (blind, deaf)	☐ Spina Bifida	☐ Unknown diagnosis
☐ Other:			

SPOKANE REGIONAL HEALTH DISTRICT

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