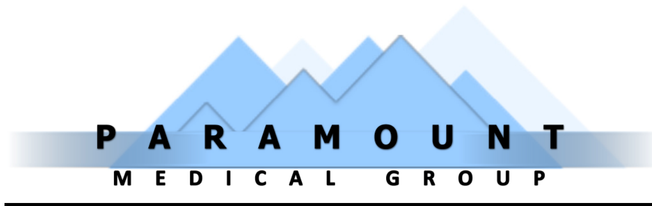

Pediatric Activity and Nutrition Evaluation Form

Today's Date: ________________

Patient Name: ____ **DOB:**______________

To be Completed by Parents/Guardians

Medical History: ____

____

Food Allergies: ______________________________Food Intolerances: ____________________________

Current Diet:

- What does your child usually eat for **Breakfast:**____

  For **Lunch**:____

  For **Dinner:**____

- How many snacks per day?________________________________

- How many servings of each does your child get in a day?
  Fruits ________Vegetables__________ Milk/dairy __________ Protein (Meats)___________

- How often in a week does your child eat the following: (daily, X times, seldom, or never)
  Soda ________ Juice__________Fried Food_______Candy/Sweets_______Salty Snacks_________
- Who Prepares Most Meals? ____
- Food Likes: ______________________________ Food Dislikes:__________________________
- Eating Related Needs: (Dental or chewing problems) ____________________________________
- Any contributing habits or risk factors to diet: _____________________________________
- BOWEL RELATED PROBLEMS: constipation __________ diarrhea____________ none_________
  Use of meds for above_________________none ____________

- Medications/Vitamin Supplements: ____

Physical Activity None______ Moderate______ Active_____ Gym or health club member?_____

Describe physical activities: ____

Activity likes and dislikes: ____

How much time/day does your child spend: TV _________Computer_________Video Games_________