

# Nutrition Questionnaire For Babies And Children 0-10 Years

Child's first names:..... Surname:.....

Address:.....

.....Post Code:.....

Tel No home:..... Parent/carer work no:.....

Email:..... Fax Number: ..... Mobile No:.....

Child's / Baby's age: .....years .....months Child's / Baby's Weight: .....kgs

Child's Baby's Height: .....metres Ethnic Origin:.....

**Main Reasons For Visit:**.....

.....

.....

.....

.....

## **Family Details:**

Mother Name: ..... Age:.....

Health problems: .....Are you the birth mother?

Father Name: ..... Age:.....

Health problems: .....Are you the genetic father? .....

## Brothers/sisters:

Male/Female..... Age:..... Health problems.....

Male/Female..... Age:..... Health problems:.....

Male/Female..... Age:..... Health problems:.....

Male/Female..... Age:..... Health problems:.....

Are there any particular illnesses and/or allergies in the family (eg heart disease, diabetes, asthma, eczema, hay fever, food allergies etc) - state which:.....

.....

.....

## **Home Life:**

1. Who lives at home with child? .....

2. Does your child have access visits to a parent? .....

3. Is your child part of a step-family?.....

4. Does your child attend day nursery, child minder, playgroup, school or special school? (Please underline)

5. Does your child have home tutoring?.....

6. Occupation of mother .....Occupation of father.....

7. Please detail if there are any pets at home.....

**GP Details:**

GP Name:.....

Address:.....

..... Tel No:.....

Is your GP aware you are consulting a nutritional therapist? **Yes/No**

Are you happy for your GP to be kept informed? **Yes/No**

Any other health professionals involved in your child's care:.....

**Pregnancy Details:**

1. Previous pregnancies including any miscarriage or neo-natal death .....

2. Contraceptive history eg the pill, coil, spermicides .....

When last used and for how long? .....

3. Did you follow a pre-conceptual care programme (eg Foresight) to optimise health? **Yes/No**

4. Did you conceive this child naturally? **Yes/No**

5. Did you receive any fertility treatment prior to conceiving? **Yes/No**

Details:.....

6. Did you experience any complications in pregnancy? **Yes/No**

Bleeding	<b>Yes/No</b>	Excessive water retention	<b>Yes/No</b>
Nausea/morning sickness	<b>Yes/No</b>	Pregnancy diabetes	<b>Yes/No</b>
Pre-eclampsia	<b>Yes/No</b>	High Blood Pressure	<b>Yes/No</b>
Thrush	<b>Yes/No</b>	Cystitis	<b>Yes/No</b>

7. Did you receive any treatments for any of the above? **Yes/No**

**If yes, what treatments and for which?**.....

8. Did you suffer any illnesses in the pregnancy, eg viruses, operations etc

.....

**Any treatments?**.....

9. Please detail any medical tests during pregnancy eg how many scans, blood tests and what stage

.....

.....

10. Did you take any of the following? Please state how much and at what stage in pregnancy

Cigarettes **Yes/No** .....

Alcohol **Yes/No** .....

Tea/coffee/cola **Yes/No** .....

Prescribed medication **Yes/No** .....

(eg antibiotics, anti-depressants, anti-nausea)

Over the counter drugs **Yes/No** .....

Street drugs **Yes/No** .....

Nutritional supplements **Yes/No** .....

11. Did you travel abroad much prior to or during the pregnancy? **Yes/No**

Where and when.....

12. How active was the baby before the birth? .....
13. Any additional information about this pregnancy.....  
.....
14. Did you suffer from thrush/cystitis after delivery? **Yes/No**  
State which and when:.....

**Diet in pregnancy**

1. Was your appetite affected? **Increased/Decreased**  
At what stage of pregnancy? .....
2. Did you lose or gain excessive weight? .....
3. How often did you eat meat/fish in a week?.....
4. Did you exclude any foods?  

Wheat	<b>Yes/No</b>	Citrus fruits	<b>Yes/No</b>	Eggs	<b>Yes/No</b>
Dairy products	<b>Yes/No</b>	Sugar	<b>Yes/No</b>	Fish	<b>Yes/No</b>
Additives	<b>Yes/No</b>	Yeast	<b>Yes/No</b>	Meat	<b>Yes/No</b>
Other.....					
5. Did you 'go off' any foods? .....
6. Did you crave any foods or non-foods?.....

**Birth Details**

1. Was this your first labour? **Yes/No**
2. Duration of pregnancy (normal gestation is 40 weeks)  
.....  
.....
3. Did you go into labour spontaneously? .....
4. Were you induced?..... 5. Length of labour  
.....
6. Medications during labour eg gas and air, epidural, pethidine.....
7. Type of birth:  
Normal vaginal delivery ..... Planned caesarean? ..... Water birth .....  
Forceps or ventous ..... Emergency caesarean .....  
Place of birth:  
Hospital: ..... Home: ..... GP unit: .....Other.....  
Birth weight.....grams
8. Birth head circumference:..... 12. Birth length:.....
13. Birth centile on growth chart, eg 50<sup>th</sup>, 25<sup>th</sup> (*Please bring baby book*) 14. Apgar score.....
15. Did your baby suffer: Jaundice..... Oxygen deficit .....
16. Did your baby require special care? **Yes/No** Why/duration? .....
17. Additional information about labour/birth .....
- .....  
.....

## CHILD'S HEALTH PROFILE

### Medical history

1. Has your child suffered infections requiring antibiotics? **Yes/No**  
If yes, please give age, illness, treatment.....
2. Does/has your child take/taken any other prescribed medications? **Yes/No**  
If yes, please give age, illness, treatment.....
3. Does your child take over the counter medications? **Yes/No**  
If yes, which and for what eg Calpol or anti-histamines.....
4. Has your child ever been referred to a specialist? **Yes/No**  
If yes, please give age, reason, type of specialist.....
5. What tests has your child had by GP, specialist, other?.....
6. Has your child received a medical diagnosis of any condition? **Yes/No**  
If yes, please expand (eg asthma, coeliac disease, anaemia).....  
.....
7. Have you sought 'alternative' health care advice for your child eg homeopath, cranial osteopath ..... **Yes/No**
8. Any other medical information?.....  
.....

### Developmental History

1. Has your GP, Health Visitor or any other medical practitioner ever expressed concern regarding your child's development? **Yes/No**  
If yes, please expand eg speech, learning, walking etc.....
2. Have there been any hearing problems ..... **Yes/No**
3. Has your child's growth pattern been 'normal' eg height, weight, growth centile **Yes/No**  
If no, please detail... ..

### Immunisation Programme

1. Has your child received the recommended standard immunisations? **Yes/No**  
If no, please detail those given and those excluded and why?  
.....
2. Has your child ever had an adverse reaction to any vaccine? **Yes/No**  
If yes, please expand.....
3. Has your child had any of these infectious diseases? (Please underline)  
whooping cough, measles, chicken pox, mumps, rubella, scarletina, herpes

## CHILD'S HEALTH PROFILE / SYMPTOMS ANALYSIS

Please underline all that apply now. Please highlight all that previously applied

Symptoms	Symptoms	Symptoms
Poor eyesight Rashes Mouth ulcers Diarrhoea Conjunctivitis / sticky eyes Thrush Chest or urinary infections Dry, flaky skin Frequent colds/infections Nose bleeds	Muscle tremors Lethargy Bedwetting Short attention span Lack energy Loss of appetite Grinds teeth Anxiety or tension Nausea or vomiting Insomnia	<b>Muscle cramps/twitches</b> <b>Insomnia</b> Tooth decay <b>Joint pains</b> Brittle nails Nervousness Bed wetting
Near sightedness Tooth decay Muscle cramps/pain Sweaty <b>Sore joints</b> Excessive tiredness Thin hair/hair loss Chilblains Dry skin	Nausea Learning difficulties <b>Swollen ankles or hands</b> Muscle pains Nervous or depressed Fits/convulsions Pins and needles Fatigue Irritability	Learning difficulties Poor sleep <b>Anxiety</b> Colic Hyperactivity Fits or convulsions Constipation Muscle weakness Bed wetting
Rashes Easy bruising <b>Slow wound healing</b> Weak muscles <b>Fatigue on exertion</b> Nappy rash Frequent infections	Slow growth Poor hair condition Eczema/dermatitis Anxiety/tension <b>Lack of energy</b> Constipation Pale skin Irritability Loss of appetite	Pale skin <b>Lack of energy/lethargy</b> <b>Nausea</b> <b>Loss of appetite</b> Slow growth Headaches Slow learning
Rashes Red pimples on skin eg upper arms Easy bruising Slow wound healing Nose bleeds <b>Frequent colds</b> <b>Frequent infections</b> Lack of energy	Fatigue Insomnia Poor memory Breathlessness Irritability Eczema Tummy ache Sore lips Poor appetite Anxiety	Rashes Poor appetite Slow growth White spots on nails Slow wound healing Pale skin Prefers strong, salty flavours Moody Frequent infections Nausea
Sore eyes Irritability Sore muscles Poor concentration/memory Insomnia Learning difficulties Tummy aches Constipation Regular pins and needles Lack of energy	<b>Dry skin</b> Poor hair condition <b>Nausea/lack of appetite</b> Eczema/dermatitis Drowsiness Diarrhoea Muscle pains Fatigue	<b>Growing pains</b> Sore knees Fits or convulsions Dizziness Diabetes Dermatitis Slow growth Learning difficulties Fatigue
Fatigue <b>Eye problems</b> Bedwetting Dry, itchy skin Poor hair condition Slow learning Sore lips Eczema/dermatitis Tendency to allergies	Poor memory Frequent infections Excessive thirst Rashes Learning difficulties Dry skin Eczema Nappy rash Sore eyes Poor wound healing	<b>Poor growth</b> <b>Family history cancer</b> <b>Visual defects</b> <b>Frequent infections</b> <b>Skin disorders</b>
Tendency to allergies Lack of energy Diarrhoea Poor sleeper Poor memory Easily distracted Headaches or migraine Irritability Bleeding gums Tendency to depression		<b>Addicted to sweet foods</b> Depression Irritability Needs frequent meals Drowsiness Learning problems Thirst Sweaty Dizziness

## CHILD'S HEALTH PROFILE

Please underline all that apply now. Please highlight all that previously applied.

### Miscellaneous symptoms

ear ache	poor co-ordination	obsessive behaviour
catarrh	head banging/rocking	mood swings
colic	sensitivity to noise	thrush
excessive crying	phobias	night terrors
aggression	shows no fear	disturbed sleep
constant runny nose	recurrent chest infections	
snoring	threadworms	

### Specific disorders

Asthma	ADD/ADHD	Downs Syndrome
Eczema/Dermatitis	Autism/Autism Spectrum Disorder	Cleft Palate
Hayfever	Aspergers Syndrome	Heart Disease
Food Allergies	Epilepsy	Sickle Cell Anaemia
Scabies	Arthritis/Still's Disease	Cystic Fibrosis
Dyslexia	Crohn's Disease	Diabetes
Dyspraxia	Phenylketonuria	Haemophilia
Cerebral Palsy	AIDS	Cancer

### Child's personality/behaviour

nervous	irritable	contented	plays well alone	popular
unhappy	a 'holy terror'	very 'good'	easily distracted	sociable
temper tantrums	restless	wide awake	learning difficulties	tip toes
impulsive	tough	tidy	'gifted' child	affectionate
excitable	emotional	messy	lazy/lethargic	rejects affection
nail biter	'all over the place'	clumsy	sleepy	agile

### Lifestyle Factors

#### Activity Profile:

1. How much time per day does your child watch TV?.....
2. How much time per day does your child use a computer (including school and home)? .....
3. How much exercise does your child have in a week?.....
4. What sport does he/she play?.....
5. Any active hobbies/clubs (eg dancing).....

#### Digestive Profile

1. Does your child chew food well? **Yes/No**
2. Does your child suffer from bad breath? **Yes/No**
3. Does your child suffer tummy upsets? **Yes/No**
4. Does your child suffer with an itchy bottom? **Yes/No**
5. Does your child have a daily bowel movement? **Yes/No**
6. Does your child suffer from diarrhoea? **Yes/No)**
7. Does your child suffer from constipation? **Yes/No)**
8. Does your child suffer from bloating/excessive wind? **Yes/No**
9. Are the stools normal, pale, offensive, floating (please underline which)

#### Immune Profile

1. Does your child suffer frequent colds, coughs, infections? **Yes/No**
2. Does your child have eczema, asthma, hayfever, arthritis (please underline which)

3. Does your child suffer from food sensitivity? **Yes/No**
4. Have you noticed any adverse reactions in your child after eating certain foods? If so, state which foods and what reactions.....

**Pollution profile**

1. Does your child live in a city or by a busy road? **Yes/No**
2. Does your child live in a smoky atmosphere? **Yes/No**
3. Does your child usually drink filtered or bottled water? **Yes/No**
4. Does your child eat non-organic foods? **Yes/No**
5. Is the main home near to: pylons, mobile phone mast, factory, petrol station, agricultural land, flight path (please underline which)
6. Does your child have a TV or computer in their bedroom?.....
7. Does your child have a mobile phone which is used regularly? .....

**Nutritional Information - Child's Feeding History**

1. Did you breast feed at all? **Yes/No** For how long?.....
2. Did you take any caffeine, cigarettes, alcohol, whilst breast feeding (underline which)
3. Did you require any medications whilst breastfeeding? **Yes/No**  
If yes - which? .....
4. Did you bottle feed at all? **Yes/No** From what age?.....  
Which formula? .....
- Which if any special formula were required eg soya, cassein free?.....
5. How old was your baby when you started weaning onto solids?.....
6. Which foods were introduced and in what order?  
1..... Any reactions..... Age:.....  
2..... Any reactions..... Age:.....  
3..... Any reactions..... Age:.....
7. At what age did you introduce the following?  
Wheat..... Any reactions.....  
Whole cow's milk ..... Any reactions.....  
Egg ..... Any reactions.....  
Peanuts..... Any reactions.....  
Citrus fruits..... Any reactions.....
8. Did you offer ready made baby foods? **Yes/No** At what age?.....

**Current Eating Habits**

9. Would you describe your child's appetite as...good...medium.poor (please underline)
10. Is your child a 'fussy' eater? **Yes/No**

11. Is your child currently following a specific dietary regime, eg gluten free? Please describe.....  
 .....  
 .....
12. Are there any foods which your child craves? Please describe.....  
 .....  
 .....
13. Are there any foods which your child dislikes intensely? Please describe.....  
 .....  
 .....
14. Do you go out of your way to avoid giving foods containing preservatives and additives? **Yes/No**
15. Do you avoid giving foods which contain sugar?.....**Yes/No**
16. How many cans of fizzy drinks does your child drink in a week?.....
17. How many times a week does your child have meals containing fried or fast foods (eg fish fingers, McDonalds) .....
18. How many portions daily of fruit and vegetables does your child have?.....
19. How many slices of bread or rolls does your child eat in a week?.....
20. Do you normally eat white or wholemeal rice, pasta and flour?.....
21. Does your child eat at nursery or at school?..... **Yes/No**  
 If yes, please describe this food/drink.....
22. Does your child take a 'lunch box' ..... **Yes/No**
23. What nutritional supplements does your child take on a daily basis? (*Please bring with you*)  
 .....

**Additional Comments:**

**Acknowledgements: Sally Child SRN, HV, Dip ION – Nutritional Therapist  
 Hyperactive Children’s Support Group (HACSG)**

## CHILD'S FOOD DIARY

**PLEASE COMPLETE FULLY**

**KEY:** S = School      H = Home      N = Nursery

<u>Day 1</u>	Approx times	<u>S</u>	<u>H</u>	<u>N</u>	<u>Day 2</u>	Approx times	<u>S</u>	<u>H</u>	<u>N</u>
Breakfast					Breakfast				
Lunch					Lunch				
Tea					Tea				
Snacks					Snacks				
Drinks					Drinks				

<u>Day 3</u>	Approx times	<u>S</u>	<u>H</u>	<u>N</u>	<u>Day 4</u>	Approx times	<u>S</u>	<u>H</u>	<u>N</u>
Breakfast					Breakfast				
Lunch					Lunch				
Tea					Tea				
Snacks					Snacks				
Drinks					Drinks				

<u>Day 5</u>	Approx times	<u>S</u>	<u>H</u>	<u>N</u>	<u>Day 6</u>	Approx times	<u>S</u>	<u>H</u>	<u>N</u>
Breakfast					Breakfast				
Lunch					Lunch				
Tea					Tea				
Snacks					Snacks				
Drinks					Drinks				