Nutrition Intake

Pt. Name _____

Date _____

Please take a moment to fill out this form so that we can get to know your family's habits better. You can email it back to us at office@yumpediatrics.com before your visit:

How many servings of fruits and vegetables does your child eat per day?_____

How many days a week does your child skip breakfast? _____

How many days a week does your child get school lunch? _____

How many nights a week does your family eat dinner together? _____

How many snacks does your child eat per day? _____

How many ounces of fruit juice does your child drink per day? _____

How many ounces of milk does your child drink per day? _____ What type?_____

How many times a day does your child drink other sweet drinks (sports drinks, soda, Kool Aid, energy drinks, lemonade, sweet tea, flavored milk)?_____

Does your child have any dietary restrictions/allergies/sensitivities? Yes No
If yes, please describe:

_____

_____

Please list a few foods your child likes (any foods including very nutritious to less nutritious):

_____

_____

Please list a few foods your child DOES NOT LIKE (any foods including very nutritious to less nutritious):

_____

_____

How many hours of screen time per day?_____ Is there a TV in the bedroom?_____

How many minutes of physical activity does your child get per day?_____

How many hours of sleep does your child get per day?_____

In the past year have you every worried you would run out of money to buy food? (circle) Yes No

How willing is your child to try unfamiliar foods (circle one)

very willing somewhat willing not very willing unwilling/anxious

Please circle any of the problems below that your child may be experiencing:

Back pain	Anxiety	Hyperactivity
Foot/leg pain	Depression	Heartburn or abdominal pain
Joint pain	Constipation	Diarrhea