Vernon Nutrition Center - New Patient Form (Pediatric)

Patient Information

Name:_____ Age:_____ Date of Birth:_____
Address:_____
City: _____ State: _____ Zip Code:_____
Home Phone #: (___)_____

Parent/ Guardian Name:_____
Address: _____
City:_____ State:_____ Zip Code: _____
Home Phone #: (___)_____ Work Phone #: (___)_____
Email address: _____

How did you(or your child) hear about our services: _____

Referring Physician
Name: _____
Medical Group: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Phone #: (___)_____

Primary Care Physician *(if different)*
Name: _____
Medical Group: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Phone #: (___)_____

Other Physician(s) *(if any)*
Name: _____
Medical Group: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Phone #: (___)_____

Name: _____
Medical Group: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Phone #: (___)_____

Medical History Form

Please list any current or past medical conditions your child has had:

Medical Condition/ Problem	Date of Diagnosis

Please list current medications your child is taking:

Medications Currently Taking	Reason for Medication	Dose	Times per day	Length of Time taken

Please list any medications that your child is allergic to:

_____

Please list any current vitamins, minerals, or herbal supplements your child is taking:

Supplements Currently Taking	Reason for Supplement	Dose	Times per day	Length of Time taken

Weight History

In the past year, has your child gained or lost any weight? Yes ( ) No ( )
If yes, please explain: _____

In the past year, has your child grown in height? Yes ( ) No ( )
If yes, please state how many inches your have grown: _____

Has your child ever fallen below the 5th percentile weight-for-height on the pediatric growth chart? Yes ( ) No ( )
If yes, please explain: _____

Has your child ever reached above the 95th percentile weight-for-height on the pediatric growth chart? Yes ( ) No ( )
If yes, please explain: _____

Has your child participated in any nutritional counseling programs? Yes ( ) No ( )
If yes, please list: _____
_____
_____

Family History

Does your family have a history of: *(please check all that apply)*

Obesity ( ) Diabetes ( ) High Blood Pressure ( )
High Cholesterol/Triglycerides ( ) Heart Disease ( ) Cancer ( )
Other: _____

If checked yes to any above, please explain:
_____
_____

Nutrition Assessment

Does your child have any food allergies? Yes ( ) No ( )
If yes, what foods:
_____
_____

Does your child skip meals regularly? Yes ( ) No ( )
If yes, what meals?

_____

Does your child eat in relation to stress? Yes ( ) No ( )

Does your child experience food cravings on a regular basis? Yes ( ) No ( )
If yes, what foods?

_____

Does your child ever eat in the middle of the night? Yes ( ) No ( )

Has your child ever binged or purged? Yes ( ) No ( )

How many meals a week does your child eat out at a restaurant or eat take-out?

_____

Does your child purchase any meals or snacks at school? Yes ( ) No ( )
If yes, please explain which foods and the amount purchased per week:

_____

Who is responsible for your child's food shopping and preparation?

_____

Does your child currently exercise? Yes ( ) No ( )
If yes, what type of exercise and how often?

_____

Please check any of the following conditions/ symptoms that your child currently experiences on a regular basis:

Condition	**Yes**	**No**
Swallowing Problems		
Change in Taste		
Shortness of Breath		
Low Exercise Tolerance		
Irregular Heartbeat		
Heart Murmur		
Chest pains		
Poor appetite		
Heartburn/ Indigestion		

Condition	**Yes**	**No**
Nausea/ Vomiting		
Diarrhea		
Constipation		
Frequent urination		
Constant Thirst		
Snore		
Insomnia		
Daytime Sleepiness		
Fatigue		

Food Recall

Please record a sample of what your child eats on a typical day:

Breakfast _____
_____
_____
_____

Snack _____
_____

Lunch _____
_____
_____
_____

Snack _____
_____

Dinner _____
_____
_____
_____

Snack _____
_____