Infant and Child Nutrition Questionnaire

Name: _____ Date: _____

1. Please list any current medical problems:
   _____
   _____
   _____
2. Does your child had any food allergies? Yes No,
   if yes please list food allergies here:
   _____
   _____
3. List all past medical problems:_____
   _____
   _____
4. Please tell me about your child's weight history: stable ___, up and down ____
5. Please list all medications your child is currently taking:_____
   _____
   _____
6. Please list all vitamin/mineral supplements or herbs your child is currently taking:
   _____
   Vitamin D supplement? Yes No
7. Does your child exercise? Yes No
   If yes what type of exercise and how often?
   _____
   _____
8. Does your child experience problems with constipation, diarrhea, or reflux? ___ yes
   ___no which one?_____

Eating Habits:

9. Please tell me about some of your child's eating habits:
   - My child eats (please circle): baby foods purees infant cereal finger foods table foods
   - Is your child a picky eater? Yes No
   - Will your child try new foods? Yes No
   - Does your child refuse to eat certain foods? Yes No, If yes what foods?
     _____
   - Does your child have difficulty with chewing food or swallowing food or liquid? Yes No
     If yes please explain: _____
     _____
   - How would you describe your child's appetite? Excellent Good Fair Poor
   - How often do you eat out at restaurants_____
   - How often do you eat at other peoples homes?_____

- My child gets meals from ___parents ___ daycare ____babysitter ____school ____grandparent other _____.
- My child has a special diet? Yes No Type of diet_____
- How many meals does your child eat a day? _____
- How many snacks does your child eat a day? _____
- What time of day does your child eat snacks? _____
- What are your child's favorite snacks? _____
- What snacks do you offer your child? _____
- What are your child's favorite foods? _____
- What beverages does your child drink? _____
- How many glasses of water does your child drink/day?_____

10. Tell me about mealtimes?
    - Do you get into struggles with you child at mealtimes or snacktime? Yes No
    - Do you eat together as a family? Yes No If yes which meals? Breakfast Lunch Dinner
    - How long will your child sit for a meal? 15 minutes or less 15-30 minutes 30-60 minutes
11. When does your child go to bed? ____ Wake up? _____ Does your child take any naps during the day? Yes No If yes how many ____ and for how long? _____
12. Where does your child sit for meals?
    Booster high chair floor adult chair adult lap
13. Please list any questions or concerns you may have here and complete the 24 hour recall on the next page. Thank-you.

Please record below what your child typically eats in one day.

Time of day and location of meal or snack?	What did they eat? Include all food and beverages	How much did they eat or drink?	How was it prepared?	Office use