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CHILD Health and Dietary Questionnaire

Please complete and return by email to info@privategp.com or by post to Private General Practice Services, 3, Knighton Grange Road, Leicester, LE2 2LF to arrive no later than 48 hours prior to your appointment

Mother's name First Last		Date of Appointment	
Title		Mobile Number	
Address Postcode		Tel: (home/work) Email address: Is it private?	

Child's name First Last		DOB	
Child's GP Name and address		Height Weight	

Where did you hear about NUTRITION FOR HEALTH eg website, BANT website, Yellow Pages, advert, flyer, through a friend?	
If you 'googled', what did you type in?	

REASON FOR CONSULTATION

Please list child's current health concerns, and how long he/she has had them. Health Problem	Duration eg 6mo, 2yrs etc
What seems to alleviate these problems:	
What makes them worse?	

SYMPTOM PROFILE

Please state 'C = currently' and 'P = previously' to any symptoms below that your child or baby is experiencing:

_ Excessive wind _ Rash _ Aggression _ Vomiting _ Ear ache _ Excessive crying
_ Diarrhoea _ Frequent colds + infections _ Frequent coughs _ Bed wetting _ Constipation
_ Nappy rash _ Anxiety _ Colic _ Cradle cap _ Phobias _ Poor appetite _ Thrush
_ Sweet/sweet food addiction _ Nose bleeds _ Conjunctivitis _ Hyperactivity _ Growing pains
_ Short attention span

Other or additional info:

MEDICAL HISTORY

Please state 'yes' to any medical conditions that apply:

_ Whooping cough _ Thread worms _ Cleft palate _ Scabies _ Down's syndrome
_ Eczema or dermatitis _ Coeliac disease _ Arthritis (Still's disease) _ Cystic fibrosis
_ Epilepsy _ Sickle cell anaemia

Please list further details of medical history, including dates.
Please also note any operations or procedures, and any other relevant information:

MOTHER'S PREGNANCY / DELIVERY PROFILE

Are you the child's birth mother?
Are there older siblings? yes/no How old? _____
Did you/mother smoke whilst pregnant yes/no or breast feeding yes/no
Did you/mother drink alcohol whilst pregnant yes/no or breast feeding yes/no
Did you/mother drink coffee yes/no and/or tea whilst pregnant yes/no or breast feeding yes/no
Did you/mother have thrush yes/no cystitis yes/no whilst pregnant or before.
Was thrush treated? yes/no Treatment used: _____
Do or did you/she suffer from postnatal depression? yes/no
If yes, please state treatment used: _____

Assisted pregnancy or infertility treatment? yes/no

Difficulties/symptoms during pregnancy e.g. gestational diabetes, bleeding, sickness, cravings, high blood pressure, pre-eclampsia, etc. If yes, treatment received: _____

Additional info:

BIRTH PROFILE

Describe type of delivery: normal, forceps, Caesarian section, etc: _____

Was the baby delivered full-term, early/late (by how many days?) _____

Birth weight: _____

Country of birth: _____

Did the baby suffered from jaundice _, stress _, oxygen deficit _, zinc deficit _.

Additional info:

FEEDING + WEANING

Was/is your child breast fed? yes/no. Age stopped breast feeding: _____

Was/is your child bottle fed? yes/no. If currently, please state formula: _____

Age began weaning: _____

Did you mostly prepare baby foods from scratch or use jars?

State order of food introduction, give months of age beside food:

1.

2.

3.

4.

5.

6.

Age introduced to: cow's milk: _____ months; wheat products (bread/Weetabix etc) _____ months; eggs: _____ months.

FAMILY HEALTH PROFILE

Please state any illnesses or allergies suffered by family members, in the space below:

Child's mother:

Child's father:

Child's sisters:

Child's brothers:

Maternal grandparents:

Paternal grandparents:

Child's aunts or uncles:

PERSONALITY PROFILE

Please state 'yes' to any of the behavioural descriptions below that match your child or baby:

_ Contented _ Excitable _ Restless _ Head Banging _ "Very Good" _ Discontented _ Wide Awake _ Aggressive _ Nervous _ Learning Difficulties _ Very "Neat" _ Irritable _ Clumsy

Other or additional info:

IMMUNISATION HISTORY

DATE	TYPE	REACTION (If any)

CHILD'S FOOD	
Is child following any particular dietary programme currently? Has he/she done in the past?	
How many times a day are the following eaten? Slices of bread/toast Helpings of vegetables Helpings of fruit Chocolate/sweets Biscuits/cake/rusks Milk Squash Fruit juice Water	 …… …… …… …… ……
How many times a week are the following eaten? Potatoes Chips Pasta Pizza Rice Cheese Beef, pork or lamb Chicken, turkey or game Sausages Chicken nuggets etc Hamburgers Oily fish e.g. salmon, sardines White fish e.g. cod, haddock Fish fingers Nuts/seeds Beans, lentils, chickpeas Salad ingredients Eggs Yoghurt Cakes/ biscuits/ cereal bars Chocolate or sweets Savoury snacks /crisps	 ……

What does he/she have as spread on bread/toast, etc? (eg jam, marge, butter, marmite, cheese)	
What oils/fats do you cook with?	
What methods of cooking do you use? Steam Boil Microwave Roast Grill Stir-fry Bake Fry	 Yes/No Yes/No Yes/No Yes/No Yes/No Yes/No Yes/No Yes/No
Do you add salt in cooking?	Yes/No
Does he/she normally eat fast?	Yes/No
Does he/she enjoy mealtimes?	Yes/No
Who usually decides when your child is finished eating?	
What foods does he/she particularly like?	
What foods does he/she particularly dislike?	
Are meals at regular times? Snack times?	
Does he/she eat alone or with siblings/parents?	

Other Notes on food or eating habits that you would like to add:

MEDICATIONS please list *current* medications and dosage or *bring with you to consultation*

MEDICATIONS please list medications taken *previously* and for what reason

SUPPLEMENTS please list any supplements currently taken eg vitamins, minerals, herbal medicines, stating the name, brand, strength and dosage. *Ideally bring with you to consultation.*

WHAT WOULD YOU LIKE TO ACHIEVE FROM THIS PROGRAMME?

If there is anything else you would like me to know please add:

Food Diary To provide me with a 'snapshot' of what your child currently eats, please write a detailed description of EVERYTHING child eats and drinks over a 4-day period (to include a weekend day). Please indicate whether you cooked from scratch, whether it was pre-prepared or from a restaurant/take away and how it was cooked/heated e.g. baked, fried, roasted, grilled, steamed, microwaved etc. Please fill in activity and wellbeing sections and any symptoms.

	Day 1	Day 2	Day 3	Day 4
Wake time **Bed time**				
Breakfast **Time**				
Snack **Time**				
Lunch **Time**				
Snack **Time**				
Tea **Time**				
Snack **Time**				
Beverages **Type** **Total for day**				
Water **Total for day**				
Exercise/activity				
Physical, Mental or Emotional Feelings or Symptoms				