PRIVATE AND CONFIDENTIAL

Institute for Optimum Nutrition
AVALON HOUSE, 72 Lower Mortlake Road, Richmond Surrey TW9 2JY ©

Nutrition Questionnaire For Babies And Children 0-10 Years

This questionnaire is designed to provide your nutritional therapist with all the information necessary to build your child an individual nutritional programme specifically tailored to his/her needs. Please answer the questions as accurately as you can.

Child's first names: Surname: Date of birth:

Address:

Post Code:

Tel No home: Parent/carer work no:

Mobile No: Email: Fax Number:

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 (e.g. 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 stepfamily?
4. Does your child attend? **(Please underline)** Day Nursery Child Minder Playgroup School or Special School
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 e.g. the pill, coil, spermicides _____

   When last used and for how long? _____

3. Did you follow a pre-conceptual care programme (e.g. 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	**Yes / No**	Excessive water retention	**Yes / No**
Nausea/morning sickness	**Yes / No**	Pregnancy diabetes	**Yes / No**
Pre-eclampsia	**Yes / No**	High Blood Pressure	**Yes / No**
Thrush	**Yes / No**	Cystitis	**Yes / No**

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, e.g. viruses, operations etc. _____

   Any treatments?

   _____

9. Please detail any medical tests during pregnancy e.g. how many scans, blood tests etc 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** (e.g. 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	**Yes / No**	Citrus fruits	**Yes / No**	Eggs	**Yes / No**
Dairy products	**Yes / No**	Sugar	**Yes / No**	Fish	**Yes / No**
Additives	**Yes / No**	Yeast	**Yes / No**	Meat	**Yes / No**

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 e.g. gas and air, epidural, pethidine _____
7. Type of birth: **(Pease underline)**

   Normal Vaginal Delivery Planned Caesarean Water Birth

   Forceps or Ventouse Emergency Caesarean
8. Place of Birth: **(Pease underline)**

   Hospital Home GP Unit Other
9. Birth Weight _____ grams
10. Birth head circumference: _____
11. 12. Birth length: _____
12. Birth centile on growth chart, e.g. 50th, 25th etc. **(Please bring baby book)**
13. 14. Apgar score: _____
12. Did your baby suffer: **(Pease underline)** jaundice oxygen deficit any other problems
13. Did your baby require special care? **Yes / No** Why/duration? _____
14. 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 e.g. 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 (e.g. Asthma, Coeliac Disease, Anaemia) _____

   _____

7. Have you sought 'alternative' health care advice for your child e.g. 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 e.g. speech, learning, walking etc.

   _____

2. Have there been any hearing problems? **Yes / No**

3. Has your child's growth pattern been 'normal' e.g. 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 all that apply)**

   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	**Muscle cramps/twitches** **Insomnia** Tooth decay **Joint pains** Brittle nails Nervousness Bed wetting
Near sightedness Tooth decay Muscle cramps/pain Sweaty **Sore joints** Excessive tiredness Thin hair/hair loss Chilblains Dry skin	Nausea Learning difficulties **Swollen ankles or hands** Muscle pains Nervous or depressed Fits/convulsions Pins and needles Fatigue Irritability	Learning difficulties Poor sleep **Anxiety** Colic Hyperactivity Fits or convulsions Constipation Muscle weakness Bed wetting
Rashes Easy bruising **Slow wound healing** Weak muscles **Fatigue on exertion** Nappy rash	Slow growth Poor hair condition Eczema/dermatitis Anxiety/tension **Lack of energy** Constipation Pale skin Irritability Loss of appetite	Pale skin **Lack of energy/lethargy** **Nausea** **Loss of appetite** Slow growth Headaches Slow learning
Rashes Red pimples on skin eg upper arms Easy bruising Slow wound healing Nose bleeds **Frequent colds** **Frequent infections** Bleeding gums 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	**Dry skin** Poor hair condition **Nausea/lack of appetite** Eczema/dermatitis Drowsiness Diarrhoea Muscle pains Fatigue	**Growing pains** Sore knees Fits or convulsions Dizziness Diabetes Dermatitis Slow growth Learning difficulties
Fatigue **Eye problems** 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	**Poor growth** **Family history cancer** **Visual defects** **Frequent infections** **Skin disorders**
Tendency to allergies Lack of energy Diarrhoea Poor sleeper Poor memory Easily distracted Headaches or migraine Irritability Bleeding gums Tendency to depression		**Addicted to sweet foods** Depression Irritability Needs frequent meals Drowsiness Learning problems Thirst Sweaty Dizziness

CHILD'S HEALTH PROFILE

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

Miscellaneous symptoms

Earache	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
Unhappy	A 'Holy Terror'	Very 'Good'
Temper Tantrums	Restless	Wide-Awake
Impulsive	Tough	Tidy
Excitable	Emotional	Messy
Nail Biter	'All Over the Place'	Clumsy

Lifestyle Factors

Plays Well Alone	Popular
Easily Distracted	Sociable
Learning Difficulties	Tip Toes
'Gifted' Child	Affectionate
Lazy/Lethargic	Rejects Affection
Sleepy	Agile

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 (e.g. dancing) _____

Digestive Profile (Please circle as appropriate)

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? **Yes / No**
   If yes, 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)**
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 **(Please underline)**

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 e.g. soya, casein 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 cows 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: **(please underline)** good medium poor

10. Is your child a 'fussy' eater? **Yes / No**

11. Is your child currently following a specific dietary regime, e.g. gluten free? **Please describe** _____
    _____

12. Are there any foods that your child craves? **Please describe** _____
    _____

13. Are there any foods that 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 that 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 (e.g. 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? _____

CHILD'S FOOD DIARY

Please complete fully

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

DAY 1	Approx times	S	H	N	DAY 2	Approx times	S	H	N
Breakfast					Breakfast				
Lunch					Lunch				
Tea					Tea				
Snacks					Snacks				
Drinks					Drinks				

DAY 3	Approx times	S	H	N	DAY 4	Approx times	S	H	N
Breakfast					Breakfast				
Lunch					Lunch				
Tea					Tea				
Snacks					Snacks				
Drinks					Drinks				

DAY 5	Approx times	S	H	N	DAY 6	Approx times	S	H	N
Breakfast					Breakfast				
Lunch					Lunch				
Tea					Tea				
Snacks					Snacks				
Drinks					Drinks				