# Nutrition Questionnaire For Children 11-16 Years

Child's First Names:…..…… Surname:.....……Gender: M / F……..

.

Address:.....……...

.....……  Post Code:.....…….……

Tel No home:……..... Parent/carer work no:.....……..

.

Email:…….  Fax Number: ….……Mobile No:…….

Child's age: .....years .....months  Date of birth: ……..  Ethnic Origin: ……

Child's Height: .....……metres  Child's Weight: ...……kgs

**Main Reasons For Visit**:.....……

.....……

.....……..

.....……...

**Family Details:**

*Mother* Name: ……..Age:……Occupation:……

Health problems: ……Are you the birth mother? ……

*Father* Name: ……..Age:……Occupation:……

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 (eg 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 step-family?…… ……

4. Please detail if there are any pets at home…… ……

**Details of Education:**

1. Does your child attend mainstream school or special school? (Please underline)

2. Does your child have home tutoring?…….. ……

3. Has your child ever received a statement of educational needs? …….. **Yes / No**

4. Does your child receive extra educational help at school ? …….. ……**Yes / No**

   If yes, please expand……..…

**GP Details:** GP Name:……GP 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. Did you receive any fertility treatment prior to conceiving or conceive this child naturally ? ***Please underline***
3. Did you have any complications / treatments in pregnancy? **Yes / No**
4. Did you suffer any illnesses in the pregnancy, eg viruses, operations etc
5. Any additional information about this pregnancy…… …….
6. Did you suffer from thrush or cystitis before / during / after delivery? **Yes / No**
7. State which and when:…….. ……

**Diet in pregnancy**

1. Did you exclude any foods?……..……...
2. Did you 'go off' any foods? ……..…
…
3. 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 have a spontaneous or induced labour? ……5. Length of labour ……
4. *Type of birth*:
   Normal vaginal delivery …….. Planned caesarean ……..…Water birth……
   Forceps or ventouse …….. Emergency caesarean …….
6. *Place of birth*:
   Hospital: ……. Home: …….. GP unit: ….…….. Other……
7. Birth weight…….. grams
8. Birth centile on growth chart, eg 50th, 25th etc (*Please bring baby book if you can find it!*)
9. Did your child require special care? **Yes/No** Why / duration? ……..….

**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 eg 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 (eg asthma, coeliac disease, anaemia)…….
7. Have you sought 'alternative' health care advice for your child eg homeopath, cranial osteopath **Yes/No**
8. Any other medical information?…….……

**Developmental History**

1. Has your child's growth pattern been 'normal' eg height, weight, growth centile **Yes/No**
   If no, please detail……

2. Has your GP, Health Visitor or any other medical practitioner ever expressed concern regarding your child's development? **Yes/No**

   If yes, please expand eg speech, learning, walking, hearing, vision ……..…

**Immunisation Programme**

1. Has your child received the recommended standard immunisations including boosters, meningitis and BCG?

   **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)

   whooping cough, measles, chicken pox, mumps, rubella, scarletina, herpes, other

**CHILD'S HEALTH PROFILE**

**Please underline all that apply now. Please highlight all that previously applied.**

**Miscellaneous symptoms**

| | | |
|---|---|---|
| ear ache | poor co-ordination | obsessive behaviour |
| catarrh | recurrent chest infections | hates bright lights |
| chronic stuffy nose | aggression | mood swings |
| stomach pains | sensitivity to noise | thrush |
| threadworms | phobias | night terrors |
| snoring | shows no fear | disturbed sleep |
| constant runny nose | travel sickness | |

**Specific disorders**

| | | |
|---|---|---|
| Asthma | ADD/ADHD | Downs Syndrome |
| Eczema/Dermatitis | Autism/Autism Spectrum Disorder | Hayfever |
| Aspergers Syndrome | Heart Disease | Cystic Fibrosis |
| Food Allergies | Epilepsy | Diabetes |
| Scabies | Arthritis/Still's Disease | Haemophilia |
| Dyslexia | Crohn's Disease | Cancer |
| Dyspraxia | Thalassaemia | AIDS |
| Cerebral Palsy | Sickle Cell Anaemia | Other |

**Child's personality/behaviour**

| | | | | |
|---|---|---|---|---|
| nervous | irritable | contented | vague | popular |
| unhappy | excitable | secretive | easily distracted | sociable |
| mood swings | restless | alert | learning difficulties | impulsive |
| tough | tidy | 'gifted' child | emotional | messy |
| lazy / lethargic | nail biter | clumsy | sleepy | agile |

**CHILD'S HEALTH PROFILE / SYMPTOMS ANALYSIS**

***Please underline all that apply now*.**

| Symptoms | Symptoms | Symptoms |
|---|---|---|
| Poor eyesight | Restlessness | **Muscle cramps/twitches** |
| Acne | Moody | **Insomnia** |
| Mouth ulcers | Tendency to allergies | Tooth decay |
| Diarrhoea | Short attention span | Joint pains |
| Eye pains / discomfort | Lack energy | Brittle nails |
| Thrush | Headaches / migraines | Nervousness |
| Chest or urinary infections | Anxiety or tension | Bed wetting |
| Dry, flaky skin | Nausea or vomiting | Frequent urination |
| Frequent colds/infections | Insomnia | |
| Nose bleeds | Asthma | |
| Near sightedness | Learning difficulties | Learning difficulties |
| Tooth decay | **Swollen ankles or hands** | Poor sleep |
| Muscle cramps | Muscle pains / cramps | **Anxiety** |
| Sweaty | Nervous or anxious | Period pains |
| **Sore joints** / bone pains | Fits / convulsions | Hyperactivity |
| Excessive tiredness | Pins and needles in hands | Fits or convulsions |
| Thin hair / hair loss | Fatigue | Constipation |
| Chilblains | Irritability | Muscle weakness |
| Dry skin | PMT | Bed wetting |
| Frequent infections | Slow growth | Pale skin |
| Easy bruising | Poor hair condition | **Lack of energy / lethargy** |
| **Slow wound healing** | Menstrual problems | Nausea |
| Weak muscles | Anxiety / tension | **Loss of appetite** |
| **Fatigue on exertion** | **Lack of energy** | Slow growth |
| Itchy skin | Constipation | Headaches |
| Acne | Pale skin | **Slow learning** |
| Poor concentration | Irritability | |
| | Loss of appetite | |
| Tendency to allergies | Fatigue | Frequent infections |
| Red pimples eg upper arms | Insomnia | Poor appetite |
| Easy bruising | Poor memory | Slow growth |
| Slow wound healing | Breathlessness | White spots on nails |
| Nose bleeds | Irritability | Slow wound healing |
| **Frequent colds** | Confusion | Pale skin |
| Frequent infections | Stomach pains | Prefers strong, salty flavours |
| Bleeding gums | Sore lips | Moody |
| Lack of energy | Poor appetite | Frequent infections |
| | Anxiety | Nausea |
| Sore eyes | **Dry skin** | **Growing pains** |
| Irritability | Poor hair condition | Sore knees |
| Sore muscles | **Nausea/lack of appetite** | **Fits or convulsions** |
| Poor concentration/memory | Eczema/dermatitis | Dizziness |
| Insomnia | Drowsiness | Diabetes |
| Learning difficulties | Muscle pains | Slow growth |
| Stomach pains | Fatigue | **Learning difficulties** |
| Constipation | Mood swings | |
| Regular pins and needles | | |
| Lack of energy | | |
| Fatigue | Poor memory | **Poor growth** |
| **Eye problems** | Frequent infections | **Family history cancer** |
| Bedwetting | Excessive thirst | **Visual defects** |
| Dry, scaly skin | **Learning difficulties** | **Frequent infections** |
| Poor hair condition | Dry skin | **Skin disorders** |
| Slow learning | Eczema | |
| Sore lips / tongue | Poor concentration | |
| Eczema/dermatitis | Sore eyes | |
| Tendency to allergies | Poor wound healing | |
| Tendency to allergies | | **Addicted to sweet foods** |
| Diarrhoea | | Depression |
| Poor sleeper | | Irritability |
| Poor memory | | Needs frequent meals |
| Anxiety | | Drowsiness |
| Headaches or migraine | | Learning problems |
| Irritability | | Thirst |
| Bleeding gums | | Sweaty |
| Tendency to depression | | Dizziness |
| Skin problems | | |

## LIFESTYLE FACTORS

**FOR GIRLS ONLY:**

1. At what age did your daughter's periods start? ……

**2.** Are the periods regular, heavy or painful? ***Please underline.***

3. Does your daughter suffer from PMT (such as sore breasts, bad temper, tiredness) before the period starts. ***Please underline***

4. Does your daughter take the contraceptive pill for period problems, acne or contraception? ***Please underline***

5. Does your daughter ever have a vaginal discharge that itches? **Yes / No**

6. Does your daughter have any irregular bleeding between periods? **Yes / No**

**FOR BOYS AND GIRLS:**

**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 your child play?……
5. Any active hobbies/clubs (eg dancing)…….
6. Does he / she walk / cycle to and from school?……..

**Immune Profile**

1. Does your child suffer frequent colds, coughs, infections? …….. **Yes / No**
2. Does your child have eczema, asthma, hayfever, arthritis, migraine (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? If so, 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 mainly non-organic foods?……..**Yes / No**
6. 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?…….. **Yes / No**
7. Does your child have a mobile phone which is used regularly?……..…… **Yes / No**

**Digestive Profile**

1. Does your child chew food well?…… **Yes / No**
2. Does your child suffer from bad breath?…… **Yes / No**
3. Does your child suffer stomach upsets?…… **Yes / No**
4. Does your child suffer with an itchy bottom?…… Y**es / No**
5. Does your child have a daily bowel movement?…… **Yes / No**
6. Does your child suffer from diarrhoea or constipation?……. *please underline*
7. Does your child suffer from bloating/excessive wind?……..**Yes / No**

**Dysbiosis Profile** ( please circle the relevant score for each question) ***Point Score***

| | | |
|---|---|---|
| 1 | During the 2 years prior to your child's birth were you bothered by recurrent vaginitis, PMT, fatigue, headache, depression, digestive disorders or 'feeling generally unwell? *(Please circle)* | **3** |
| 2. | Did / does your child suffer from thrush? | **1** if mild; **2** if severe/persistent |
| 3. | As an infant did your child have frequent nappy rashes or have any recent anal redness? | **1** if mild, **2** if severe / persistent |
| 4. | During infancy, was your child colicky and irritable lasting over three months? | **1** if mild, **2** if moderate or severe |
| 5. | Was your baby a headbanger? | **1** |
| 6. | Has your child attended a day care centre in first 3 years of life? | **2** |
| 7. | Has your child been hospitalised since birth? | **2** |
| 8. | Has your child swum in freshwater lakes or streams? | **1** |
| 9. | Has your child been on 'exotic' holidays such as the Carribean or Far East? | **2** |
| 10. | Has your child received:<br>♦ 4 or more courses of antibiotic drugs during the past year or received continuous preventative courses of anti-biotic drugs?<br>♦ 8 or more courses of 'broad spectrum' antibiotics during the past 3 years eg for chest or urinary infections?<br>♦ steroids eg for eczema or asthm**a** | <br>**8**<br>**5**<br>**4** |
| 11. | Does exposure to perfume, insecticides, petrol or other chemicals provoke moderate to severe symptoms? | **2** |
| 12. | Are his symptoms worse on damp days or in damp or mouldy places? | **2** |
| 13. | Does tobacco smoke really bother him / her? | **2** |
| 14. | Has your child been bothered by persistent or recurrent digestive problems, including constipation, diarrhoea, bloating, foul smelling stools or excessive wind? *(please circle)* | **1** if mild, **2** if moderate, **3** if severe |
| 15. | Has your child experienced recurrent or persistent athlete's foot or chronic fungus infections of skin or nails? | **2** |
| 16. | Has your child been bothered by recurrent hives, eczema or other skin problems? | **3** |
| 17. | Has your child experienced recurrent ear problems or had tubes inserted in his / her ears? | **2** |
| 18. | Has your child been bothered by persistent nasal congestion, cough and/or wheezing? | **2** |
| 19. | Has your child been labelled 'hyperactive? | **1** if mild, **2** if severe |
| 20. | Does your child have learning problems, even though his/her early developmental history was normal? | **1** |
| 21. | Does your child have a short attention span? | **1** |
| 22. | Is your child persistently irritable, unhappy and hard to please? | **1** |
| 23. | Is your child unusually tired or moody or depressed? | **1** if mild, **2** if severe |
| 24. | Does / has your child suffered recurrent headaches, abdominal pain, or muscle aches? | **1** if mild, **2** if severe |
| 25. | Is your child a bedwetter? | **1** |
| 26. | Is he/she a bottom scratcher? | **1** |
| 27. | Does your child crave sweet foods? | **1** |
| 28. | Does your child drink tap water rather than bottled or filtered water? | **1** |
| 29. | Do you have a puppy or kitten at home? | **1** |
| 30. | Do you feel that your child isn't well, yet diagnostic tests have not revealed the cause? | **1** |

**Total:……..…**

| | | |
|---|---|---|
| Total Score: (max 67) | 15 -20 | = possible |
| | 20 -30 | = probable |
| | 30 or more | = certain |

Adapted from Elizabeth Lipski 'Digestive Wellness', Keats Publishing, 2000)

## NUTRITIONAL INFORMATION

### Child's Feeding History

1. Did you breast feed at all? **Yes/No** For how long?……

2. Did you bottle feed at all? **Yes/No** From what age?……

   Which formula? ……..……..

3. Which if any special formula were required eg soya, cassein free?……..…..

4. How old was your baby when you started weaning onto solids?……..…

5. Did you offer ready made baby foods? **Yes/No** At what age?……..

### Current Eating Habits

1. Would you describe your child's appetite as…..good…..medium..…poor (please underline)

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

3. Is your child currently following a specific dietary regime ( such as gluten free )? *Please describe*……...

   ……..……

4. Are there any foods which your child craves? *Please describe*……..……...

5. Are there any foods which your child dislikes intensely? *Please describe*……..……..…….

6. Do you go out of your way to avoid giving foods containing preservatives and additives?……**Yes/No**

7. Do you avoid giving foods which contain sugar?……..**Yes/No**

8. How many cans of fizzy drinks does your child drink in a week?……..…

9. How many times a week does your child have meals containing fried or fast foods (such as fish fingers or McDonalds) ……..…

10. How many portions of fruit and vegetables does your child have daily?……..…

11. How many slices of bread or rolls does your child eat daily?…….……..

12. Does your child normally eat white or wholemeal rice, pasta and flour?……..……*please underline*

13. 

13. Does your child take a 'lunch box' or have school dinners?……....**Yes/No**

15. Does your child skip meals such as breakfast?……**Yes / No**

16. Is your child always hungry?……**Yes / No**

*17.* What nutritional supplements does your child take on a daily basis? *(please include brand and dose and bring to consultation)*

……..……

……

……..

**Acknowledgements:** **Designed by Sally Child SRN, HV, Dip ION, MBANT, Fellow ION Nutritional Therapist**

**CHILD'S FOOD DIARY**

**PLEASE COMPLETE FULLY**

**KEY:** **S = School** **H = Home** **O = Other (such as at friends or eating out)**

| Day 1 | Approx times | S | H | O | Day 2 | Approx times | S | H | O |
|---|---|---|---|---|---|---|---|---|---|
| Breakfast | | | | | Breakfast | | | | |
| Lunch | | | | | Lunch | | | | |
| Tea | | | | | Tea | | | | |
| Snacks | | | | | Snacks | | | | |
| Drinks | | | | | Drinks | | | | |

| Day 3 | Approx times | S | H | O | Day 4 | Approx times | S | H | O |
|---|---|---|---|---|---|---|---|---|---|
| Breakfast | | | | | Breakfast | | | | |
| Lunch | | | | | Lunch | | | | |
| Tea | | | | | Tea | | | | |
| Snacks | | | | | Snacks | | | | |
| Drinks | | | | | Drinks | | | | |

| Day 5 | Approx times | S | H | O | Day 6 | Approx times | S | H | O |
|---|---|---|---|---|---|---|---|---|---|
| Breakfast | | | | | Breakfast | | | | |
| Lunch | | | | | Lunch | | | | |
| Tea | | | | | Tea | | | | |
| Snacks | | | | | Snacks | | | | |
| Drinks | | | | | Drinks | | | | |

**ADDITIONAL QUESTIONS FOR YOUR CHILD TO COMPLETE**

***Some of these are sensitive questions, but having this information helps me to understand better your health concerns and adjust the diet and any supplements accordingly. If you wish, you can fill these in without mum or dad, but need to realise that there may be areas we need to discuss together with your parent / guardian.***

1. **How often do you buy food yourself such as the school canteen, tuck shop, ice cream van, vending machines, Mac Donald's ……**
2. **What time do you go to sleep and wake up?**

   **Term time……. Holidays……..……..……...**
3. **Do you find it difficult to get to sleep or to wake up?…….Yes / No**
4. **Do you eat breakfast?…….…….Yes / No**
5. **How many glasses of water do you drink in a day?……..……..**
6. **How do you get on with your brothers and sisters?…….……**
7. **Do you have any problems at school? eg with friends, work or health…….…….…**
8. **Have you ever dieted?……..…**
9. **What do you do after school?…….…**
10. **Do you have a job? (over 13years) ……Yes / No**
11. **If *yes* for how long do you work and what do you do?…….……..…**
12. **How long do you spend doing homework daily?…….**
13. **Do you have several friends?…….…..…**
14. **Do you smoke? ……Yes / No**

    **If yes, when did you start and how many daily?……..……..**
15. **Have you ever taken drugs e.g. cannabis, ecstacy, glue sniffing ……....**
16. **Do you drink alcohol?.....Yes / No**
16. **How would you describe your personality?……..…..**

    **…….**
17. **Any other comments……..…**

*Thank you for being so honest and interactive in your health. We can now achieve the most appropriate nutritional programme for your individual lifestyle.*