Tateishi Nutrition

CHILD'S INITIAL DIETARY ASSESSMENT

Date_____ ☐ Male ☐ Female

Name_____ Date of Birth_____

Address:_____ Tel. (Res.)_____

_____ (Cell)_____

Zip Code _____ email _____ (Bus.)_____

Mother's Name_____ Father's Name_____

Physician_____ Ref. From ☐ Physician ☐ Other_____

Reason for Referral_____

Medications Presently Taken_____

Please list any pertinent medical information_____

_____

Please list any food/medication/environmental allergies/sensitivities/intolerances if applicable_____

_____

Height_____ Weight_____ Weight Description from Birth to Present_____

_____

Lifestyle

Exercise/Activities List	How Often	Minutes of Activity/Session

Pregnancy History

Please respond to the following questions regarding your pregnancy with this child.

Amount of weight gained? _____
Were you nauseous? ☐No ☐Yes If yes, when?_____ duration?_____
List any medications taken _____When?_____
List any vitamin/mineral/herbal supplements taken_____
_____

Were you following My Pyramid Pregnancy guidelines ☐No ☐Yes? Explain
_____
_____

List any food cravings_____

List any complications during the pregnancy/delivery_____
_____

Infant History

Did your child have any of the following symptoms during infancy?

Symptom	No	Yes	When during infancy?
Fussy/Colicky			
Slept Poorly			
Spit Up A Lot			
Projectile Vomiting			
Diarrhea			
Constipation			
Eczema/Rashes			
Failure To Thrive			

Was your infant breast fed?. If Yes, for how long?_____
List formulas offered_____introduced at _____months.
_____introduced at _____months.
Cow's milk introduced at _____months.
If applicable, please describe any reactions your son/daughter may have had with the breast milk/formulas/milk introductions_____
_____

Were there any foods that caused any physical symptoms or behavioral changes upon initial introduction? ☐No ☐Yes. If yes, describe_____
_____

Please list any medications required, why and when_____
_____

Physical Symptom Survey

Indicate symptom frequency i.e. #/week, #/month, etc. under the appropriate category

Symptom	Infancy	2 – 5 Yrs.	Presently	Never
Asthma				
Shortness Of Breath				
Frequent Colds				
Constant Stuffy/Runny Nose				
Coughing Spells				
Hay Fever				
Excess Throat Mucous				
Nosebleeds				
Dark Circles/Puffiness Under Eyes				
Ear Infections				
Frequent Use Of Antibiotics				
Eczema/Rashes/Hives				
Fatigue				
Dizziness/Lightheadedness				
Headaches/Migraines				
Seizures				
Insomnia/Poor Sleep Patterns				
Grinds Teeth At Night				
Frequent Urination				
Kidney Or Bladder Problems				
Burping/Belching				
Gas/Flatulence				
Stomach Aches/Pains/Cramps				
Stomach Bloating				
Vomiting				
Leg Cramps/Growing Pains				
Poor Appetite				
Constantly Moving/Fidgeting				
Difficulty Concentrating				
Aggressive				
Easily Frustrated				
Temper Tantrums				
Jekyll/Hyde Behaviors				
Enuretic (Bed Wetter)				
Night Sweats				

Bowel Movements: Frequency #_____/day #_____/week _____

Consistency: ☐Formed ☐Watery ☐Loose Unformed ☐Hard Dry Color_____

Family History

Put an X in the column of the family members who have or have had these conditions. If more than one brother or sister or relative has or had these conditions, indicate by placing the corresponding number of X's in the column. Treat the "others" column (aunts, uncles, grandparents) the same way.

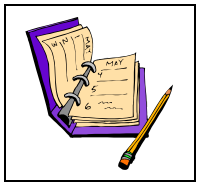
Symptom/Condition	Mother	Father	Siblings	Others
Cardiovascular Disease				
High Blood Pressure				
Obesity				
Diabetes Type 1				
Diabetes Type 2				
Hypoglycemia				
High Blood Pressure				
Spastic/Irritable Bowel Syndrome				
Constipation				
Diarrhea				
Abdominal Cramps				
Crohn's Disease				
Food Allergies				
Medication Allergies				
Asthma				
Hay Fever				
Chronic Stuffy/Runny Nose				
Frequent Colds				
Excess Throat Mucous				
Frequent Nosebleeds				
Chronic Fatigue				
Hives/Rashes/Itchy Skin				
Headaches/Migraines				
Muscle/Joint Aches/Pain/Soreness				
Arthritis ☐Osteo ☐Rheumatoid				
Osteoporosis				
Gall Bladder Problems				
Kidney Or Bladder Problems				
Liver Problems				
Neurological Disorders				
Cancer				

Other:_____

_____

Please list family members and their food, medication or environmental allergies/sensitivities/intolerances:_____

_____



Instructions for Food Diary Recording

In order to evaluate your child's dietary habits and nutrient intake, a 3-day food record is requested. Choose 3 consecutive days, including one weekend day for the most accurate analysis.

Information required on the food diary recording includes:

1. the date;
2. the clock time of your child's food consumption;
3. all foods, beverages and vitamin/mineral supplements consumed.

Please indicate the amounts of all foods and beverages your child consumed e.g.

- ½ cup or 4 oz. of white rice
- 1 cup or 8 oz. of 2% reduced fat milk;
- ¾ cup or 6 oz. of fresh squeezed orange juice
- 1 oz. baked chicken breast (no skin).

Indicate the preparation method used, e.g. fried, broiled, boiled, etc. If the food was fried, indicate what the food was fried in i.e. the brand name of the oil, margarine, butter or non-stick spray and how much was used.

Indicate any extra condiments used e.g.:

- 1 tsp. Benecol Margarine on 1 slice of sourdough rye bread
- 2 tsp. brown sugar on ½ cup of Quaker instant oatmeal, cooked.

For combination dishes, such as casseroles, stews, meat loaves or baked items, please list the ingredients and the number and size of servings.

Turkey Loaf
2 lbs. of ground turkey
½ cup of Ralph's Brand tomato paste
¾ cup dried bread crumbs
1 tsp. dried oregano Yield: 8 – 6 oz. servings

Indicate the name of any vitamin or mineral supplements your child takes and the amount. Either the empty container or labels should be submitted.

One very important point to remember when recording information, please be as accurate and as honest as possible.