Susan Macfarlane nutrition

NEPEAN SPORTS MEDICINE & PHYSIOTHERAPY CENTRE

NUTRITION INTAKE FORM: *Please complete prior to your appointment with Susan Macfarlane, MScA, RD. Information below pertains to child referred for nutritional counseling.*

Personal Data	
Child(ren)'s full name:	Gender:
Date of birth:	Email:
Primary phone number:	Alternate phone number:
Address:	
Physician's name:	Physician's phone number:
Physician address:	
Other healthcare professionals seen:	
Do you have insurance coverage for Registered Dietitians? Y/N	
How did you hear about Susan Macfarlane Nutrition?	
What is the reason for your visit today?	
How ready are you to make dietary/lifestyle changes (0 = not ready at all to 5 = I am very ready):	

Medical History
Medications, vitamins, minerals, supplements (include respective doses):
Diagnosed medical conditions:
Surgeries and date:
Has/have your child(ren) ever been diagnosed with a nutrient deficiency? Please explain.
Please list the relevant medical history of immediate family members (i.e. first degree relatives):

Social History/Lifestyle Habits			
Occupation of parents:		Marital status of parents:	
Siblings and ages:		Living arrangement of child(ren):	
Does anyone smoke in the presence of your child(ren)?			
Are your child(ren)'s immunizations up to date?			
Does/do your child(ren) attend school/daycare?		Grade:	
Describe your child(ren)'s weekly physical activity including the type, duration, and frequency:			
Screen time:	_____min in am	_____min in pm	____min in evening
Hours of sleep per night:		Any sleep difficulties?	

Food and Nutrition History				
Food allergies or intolerances:				
Favourite foods:		Disliked foods:		
Is/are your child(ren) a picky eater? Please explain.				
Are other family members picky eaters? Please explain.				
Frequency of going out to eat/week:	Restaurant(s):		Reason:	
Who is responsible for cooking/grocery shopping in your home?				
Does/do your child(ren) assist/show interest in cooking/grocery shopping?				
Where are meals eaten? Breakfast: Lunch: Supper: Snacks:		Electronic devices present? Y/N	Does/do your child(ren) skip any meals/snacks?	
How long does/do your child(ren) take to finish a meal?		Is/are your child(ren) willing to try new foods?		
Is/are your child(ren) allowed to choose their own meals/snacks? Please explain.				
Is/are your child(ren) encouraged to finish their plate at meals/snacks? Please explain.				
Is food offered as a reward to your child(ren)? Please explain.				
Is food taken away from your child(ren) as punishment? Please explain.				
Does/do your child(ren) ever sneak or hide food? Please explain.				
Does/do your child(ren) eat at a separate time or a different meal than parents/caregivers? Please explain.				
Does/do your child(ren) follow a specific eating pattern (e.g. vegan, vegetarian, Mediterranean)? Please explain.				
Please bold/highlight/circle any of the following your child(ren) experiences on a regular basis:				
Constipation	Diarrhea	Bloating	Cramping	Distention
Gas	Altered appetite	Nausea	Vomiting	Heartburn
Dizziness	Changes to skin, hair, nails			
Frequency at which the above symptoms occur:				

Beverage	Amount	Frequency
Water		
Cow's milk(%)		
Plant milk (type)		
Juice		
Regular pop		
Diet pop		
Energy drinks		
Iced tea/lemonade/sports drinks		

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Please record everything your child(ren) eats and drinks in the table below. Include as much detail as possible, including ***what*** and ***how much*** was consumed.

	Weekday 1	Weekday 2	Weekend 1
Breakfast *Time:* *Location:*			
AM Snack *Time:* *Location:*			
Lunch *Time:* *Location:*			
PM Snack *Time:* *Location:*			
Supper *Time:* *Location:*			
Bedtime Snack *Time:* *Location:*			

Please indicate which of the following topics you would like to learn more about:

- ☐ Label reading
- ☐ Cooking
- ☐ Grocery shopping
- ☐ Nutrition for active living
- ☐ Meal planning
- ☐ Balanced meals
- ☐ Mindful eating
- ☐ Plant-based nutrition
- ☐ Eating at restaurants
- ☐ Vitamin/Mineral supplementation
- ☐ Managing picky eating
- ☐ The Division of Responsibility
- ☐ Macronutrient requirements (please specify):
- ☐ Other:

Susan Macfarlane, MScA, RD
Registered Dietitian Nutritionist