Pediatric Nutrition Assessment Form

Name of Child_____ Birth Date_____ Age_____
Name of Parents_____
Address _____
Telephone numbers _____ E-mail _____
Pediatrician _____
Health Insurance _____
Referred by _____
Today's Date _____

What concerns do you have about your child's diet?

How can I help you and your child? What kind of information and support are you looking for?

Describe your child's physical activity

How much time does your child spend outside per day?
How many minutes per day is your child sitting in front of a screen?
How many hours of sleep does your child get?

Does your child experience constipation, diarrhea, loose stool, heart burn, gas, or bloating? Difficulty swallowing?

List foods that your child is allergic or digestively sensitive to and their reaction:

Height _____ Current weight _____

List all medications, vitamin, mineral, and herbal supplements that he/she is taking:
_____ _____ _____
_____ _____ _____
_____ _____ _____

Describe your child's health history and approximate date of diagnosis:
_____ _____
_____ _____
_____ _____

List significant diseases in your child's family's health history:

_____ _____

_____ _____

How would you describe your child's appetite?

Are there any foods or textures that your child dislikes?

As a family, how often do you eat out and where?

Please request your child's growth chart to be faxed to my office at 603-766-1966

Consent for Treatment and Authorization Form
for use of Protected Health Information

Patient Name: _____ DOB: _____

Parent/Guardian: _____ (applies only to patients under 18 years of age)

I hereby consent to participating in nutrition counseling and understand that all information I provide is private, confidential, and protected by law as described in the Notice of Privacy Practices.
I hereby authorize any insurance benefits to be paid directly to Melissa Snow, RD, LD Nutrition Therapist and recognize my responsibility to pay all non-covered services.
When necessary to coordinate my nutrition and healthcare, my protected health information may be obtained from and/or provided to my:

- Insurance Company
- Primary Care Doctor: _____
  Address: _____
  Phone: _____ Fax: _____
- Other Doctor (Relationship: _____)
  Name: _____
  Address: _____
  Phone: _____ Fax: _____
- Psychologist or Counselor: _____
  Address: _____
  Phone: _____ Fax: _____

Melissa Snow, RD, LD is hereby released from legal responsibility or liability for the release of information authorized herein. I understand that I have the right to revoke this authorization in writing at any time by sending notification to Melissa Snow, RD, LD at the address below. I understand that I have the right to (1) inspect or obtain a copy of the protected health information to be provided as permitted under federal and state law, and (2) refuse to sign this authorization. My signature indicates my understanding and acceptance of the above policies.

Patient Signature _____ Date _____

Parent/Guardian Signature _____ Date _____

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