Melissa Snow, RDN, LD
Pediatric Nutrition Assessment Form

Name of Child_____ Date of Birth_____ Age_____
Name of Parents _____
Address _____
Telephone numbers _____ E-mail _____
Pediatrician _____
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:
_____ _____
_____ _____
_____ _____

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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

Melissa Snow, RDN, LD
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 participate 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, RDN, LD Nutrition Therapist and recognize my responsibility to pay all non-covered services.

- In order to coordinate my nutrition and healthcare, my protected health information may be obtained from and/or provided to my (list all applicable information):

Insurance Company: _____

Primary Care Doctor: _____
Address: _____
Phone: _____ Fax: _____

Other Doctor (list type): _____
Name: _____
Address: _____
Phone: _____ Fax: _____

Psychologist or Counselor:_____
Address: _____
Phone: _____ Fax: _____

Melissa Snow, RDN, 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, RDN, 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.

Cancellation/No Show Policy: Helping you meet your goals is important to me, so I've reserved this block of time specifically for you. I also understand that sometimes in life, unexpected things come up. If you find there's no way for you to keep this scheduled appointment, please give at least 24 hours notice to reschedule or cancel by phone or email. If you are unable to give at least 24 hours notice, a $50 late cancellation fee will be billed to you. Thank you for your cooperation.

My signature below indicates my understanding and acceptance of the above policies.

Patient Signature _____ Date _____
Parent/Guardian Signature _____ Date _____