Accredited Practising Dietitian APD

CORRECT HEALTH

Date of consult: Clinic Location:

INITIAL NUTRITIONAL ASSESSMENT-PAEDIATRIC

We just need to know a little bit about you, so we can give you a customized nutritional advice.

Surname:

Given Name:

Date of Birth: (Age:)

Gender:

Your EXPECTATIONS from this appointment:

Briefly describe your health concerns

What would you like to achieve in regard to your health?

Have you had any form of dietary/nutritional counselling in the past? If so, could you please describe your experience/s?

Please list over-the-counter and prescribed medications and supplements that you are currently taking		
Name	**Purpose**	**Frequency**

Your medical history:

Your family's medical history:

Would the above reported typical meal be a WEEKDAY meal? (*Please circle the correct answer*) Yes/No

If Yes, How different would be your WEEKEND meal?

If No, how do your weekday meals differ from weekend meals?

How OFTEN do you eat out or go for takeaway foods/drinks?

What would be your usual TAKEAWAY meal?

What SNACKS do you usually eat?

Are you on a SPEICAL DIET or RESTRICTING OR AVOIDING ANY FOODS? (*Give details*)

Commonly eaten FRUITS	
Commonly eaten VEGETABLES	

Is there anything you would like to change about what you eat or drink?

Meal-time environment

	Breakfast	**Lunch**	**Dinner**
Where do you have your meal? At the ***table*** or ***on the go***			
Is screen of any form ON during each of the meal (T.V. /iPad/Phone) ?			
Do family members have meal with the child? (*put a tick where applicable*)			

Usual time taken to finish main meals?

Name: **DOB:**

FOOD AND FLUID INTAKE HISTORY

Record the current typical MEALS + FOODS & DRINKS you eat. Don't forget to include items such as oil used for cooking, spreads, sugar, stocks, sauces and brands of packaged foods or takeaway meals

FILL THIS SECTION ONLY	THIS SECTION IS FOR OFFICE USE ONLY					
	V	F	G	D	M	
BREAKFAST (TIME: ; LOCATION:) *e.g. at 8 am, at work* *Weetblx - 2* *Full cream milk – 1 cup/ 250 mls*						
MID-MORNING (TIME: ; LOCATION:)						
LUNCH (TIME: ; LOCATION:)						
MID AFTERNOON (TIME: ; LOCATION:)						
DINNER (TIME: ; LOCATION:)						
SNACK/DESSERT (TIME: ; LOCATION:)						

FOOD GROUP CHECKLIST (*please circle as appropriate*)	**WHICH ONE ? HOW OFTEN?**
Breads and Cereals	
Bread/roll	
Cereals	
Biscuits	
Cakes/Muffins	
Crumpets/Crackers	
Rice/Pasta/Couscous/other grain	
Vegetable	
Fresh/Canned/Frozen/Juice	
Fruit	
Fresh/Dried/Canned/Juice	
Dairy	
Milk	
Yoghurt	
Ice cream	
Cheese	
Other	
Meat and Alternative	
Fish	
Seafood	
Red Meat	
Poultry	
Pork	
Egg	

FOOD GROUP CHECKLIST (*please circle as appropriate*)	**WHICH ONE ? HOW OFTEN?**
Legumes/Beans/Lentils	
Soy/Tofu	
Nuts & oilseeds	
Fats/oils	
Oil	
Butter/Margarine	
Cream/Dressings/Sour Cream	
Sauces	
Fried foods	
Snacks	
Bakery	
Chips	
Chocolate/Cookies	
Pastries	
Iceblocks/Lollies	
Drinks	
Cordials/Shakes/Soft drinks	
Sweetened beverages	
Sports drinks	
Tea/Coffee	
Water	