Capital Area Pediatrics

Pre-Nutrition Questionnaire

To make the best use of our time together, please complete and upload to your patient portal at least 24 hours before your nutrition consultation.

Patient Name _____ **Date of Birth:** _____ **Today's Date:**_____

Person completing questionnaire: _____ **Relationship:** _____

1. What would you like to gain from meeting with a dietitian? Be as detailed as you can.

2. What are your nutrition goals?

3. Have you seen a dietitian before? YES / NO
4. Specify all vitamins and supplements you are presently taking.

5. Have you had any recent lab work done outside of Capital Area Pediatrics? YES / NO
   If yes, please upload results to the patient portal or bring results with you to the appointment.

6. Describe a typical day of eating including meals and snacks.

7. What kinds of beverages do you/your child consume throughout the day? Describe types, frequency, and amounts.

8. Are you allergic to any foods? YES / NO
   If yes, please list:

9. Are there certain foods that you avoid from your diet?
   If yes, please describe:

10. If you participate in physical activity, please list type(s) and duration of activity. If none, state none.

11. Do you have any kind of physical limitations? If so, please describe:

12. Please check any of the following that you/your child have experienced in the past six months:

	Increased appetite		Decreased appetite
	Difficulty sleeping		Excessive sleep
	Fatigue / low energy		Low self-esteem
	Fatigue / low energy		
	Other:		

13. What else would you like me to know before we begin working together?