



NUTRITION CONSULTING INC.

Nutrition, Exercise & Health History Form (Pediatric)

It's Your Health. Take a Stand.

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Please bring this form completed to you first appointment.

Address: 1325b – 9th Avenue SE Calgary, AB T2G 0T2

Child's Name		Gender	Date
Address City: Postal Code:		Mother's Name	Father's Name
Home Phone		Legal Guardian (if different than parent)	
Mom's Work Phone		Dad's Work Phone	
Fax		Email	
How did you hear about this service?		Age	Date of Birth
Doctor's Name	May your doctor be notified of your visit(s)?	Clinic Name Doctor's Address City: Postal Code: Fax Number: Phone Number:	
Do you have private insurance coverage for this service? Describe.	Would you like to be added to our free monthly e-newsletter? <input type="checkbox"/> Yes <input type="checkbox"/> No	Registered Dietitian name:	

Please list your nutrition questions, goals, and/or concerns

PERSONAL HEALTH HISTORY	✓	list details (example: diarrhea 4 times per day)
Allergies		
Food Intolerance		
Constipation		
Diarrhea		
Gas/bloating		
Picky Eating		
Fatigue/sleepiness		
Frequent colds/flu/coughs/runny nose/stuffy		
Fussy/cries often		
Low iron/anemia		
Frequent waking/sleeps poorly		
Eczema/rashes		
Surgery		
Blood sugar concerns		
Heart/cardiovascular/cholesterol issues		
Underweight/poor weight gain		
Anorexia/bulimia/binge eating		
Depression/anxiety/psychiatric care		
Attention deficit disorder		
Overweight		
Other		

FAMILY HEALTH HISTORY	✓	list family member (example: grandma, sister)
Health issues during moms pregnancy		
High cholesterol		
High blood pressure		
Heart disorder/heart attack/stroke		
Diabetes		
Cancer		
Osteoporosis		
Digestive issues		
Allergies		
Food intolerance		
High or low blood sugars		
Thyroid problems		
Low iron/anemia		
Overweight		
Other		
Other		

OTHER PERSONAL INFORMATION	Answer the question and list the details.	
Medications Taken (list name, dose, and what it is for) <i>Attach a list if needed</i>		
Vitamins, Minerals, Supplements, & Herbs Taken (list name and dose) <i>Attach a list if needed</i>		
Current Height and Weight (estimate or actual; and percentiles)	Weight	Height
Weight History		
Weight Goal if applicable		
Has your family/child followed a nutrition plan before? List program/book. Have you seen anyone regarding nutrition before? If yes who?		
Does your child have any food restrictions, strong dislikes, or foods your family choose not to eat for personal/cultural reasons?		
How much water does your child drink per day?		
How much pop does your child drink?		
How many times a week does your family eat out? Where – restaurant, fast food, cafeteria, take out?	BREAKFAST LUNCH SUPPER	
Who does the grocery shopping in your house?		
Who does the cooking & food preparation in your house?		
What physical activity does your child do? How long? How often?		
How much time does your child spend on: TV/internet/video games?	TV Internet Video games	

What are your child's biggest nutrition challenges?		
Other		
How satisfied are you and/or your child with the following: (rank from 1-5) 1 = very dissatisfied 5 = very satisfied	Eating Habits Fitness Level/Activity Sleep Habits Body Image/Self-esteem	Stress Management Weight/Body Composition Overall Health Energy Levels

Food Record

On the following pages you will find a 3 day food and activity record. Record everything you eat for 3 days in a row and bring this to your appointment. The food record will be used to complete a detailed nutrition assessment of your intake. Please try to be as honest and accurate as possible so that you can receive the most relevant advice.

The following information is needed:

- **Type and amount** of food consumed
eg. 3 oz. (deck of cards) boneless, skinless baked chicken breast
eg. 1 cup (1 fist) or 250 ml or 8 oz. of skim milk
- **Method** of food preparation
eg. pan fried in non-stick cooking spray
eg. fried in 2 teaspoons of canola oil
- **Brand names** of commercial products
eg. 1 cup Campbell's cream of chicken soup made with 1 % milk
eg. 1 McDonalds Big Mac
- **Condiments** added to foods
eg. 1 tablespoon regular peanut butter
eg. 1 teaspoon Becel soft tub margarine



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Food Record – Day #1

Date: _____

Please circle: I ATE less than usual the same as usual more than usual

Meal	Amount	Food Eaten and Details (eg. brand, cooking method etc.)
Breakfast Time:		
Snack Time:		
Lunch Time:		
Snack Time:		
Supper Time:		
Snack Time:		

Physical Activity



Food Record – Day #2

Date: _____

Please circle: I ATE less than usual the same as usual more than usual

Meal	Amount	Food Eaten and Details (eg. brand, cooking method etc.)
Breakfast Time:		
Snack Time:		
Lunch Time:		
Snack Time:		
Supper Time:		
Snack Time:		

Physical Activity
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Food Record – Day #3

Date: _____

Please circle: I ATE less than usual the same as usual more than usual

Meal	Amount	Food Eaten and Details (eg. brand, cooking method etc.)
Breakfast Time:		
Snack Time:		
Lunch Time:		
Snack Time:		
Supper Time:		
Snack Time:		

Physical Activity
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Company Policy



This MUST be read and signed before your dietitian can start working with you.

Rescheduling Appointments

Please help us to maintain the operation of our business on sound principles so that we may assure you and other clients uninterrupted service. Once you have made an appointment, this time is reserved for you, therefore **AT LEAST 24 HOURS NOTICE on business days** must be given if rescheduling is absolutely necessary - otherwise the session will be counted in your package or charged.

Initials

Payment of Counselling Programs

Counselling programs can be paid in advance or in full at your first appointment.

Alternatively you can select a payment plan and authorize us to charge your Visa or MasterCard (a processing fee is added to payment plans for the Blaze Program and Sizzle Program). Our payment plans are as follows:

Blaze Program – 4 payments

Sizzle Program – 4 payments

Ignite Program – 2 payments

There are no refunds for services purchased. All professional services are CHARGED DIRECTLY TO THE CLIENT (we do not direct bill insurance companies). We will prepare any necessary forms or reports to help you collect your benefits from insurance companies. Methods of payment include: cash (exact change please), cheque, debit card, MasterCard, and Visa. We also have online debit, MasterCard and Visa available on our secure website.

Initials

Counselling Program/Package Expiry

Services purchased are non-transferable, non-refundable and **expire after 6 months** of the date of your first session in a program/package. The date of expiry cannot be extended should you not be able to complete your services and sessions. It is your responsibility to ensure you book your appointments and services within the allocated time you have to complete your program.

Initials

Privacy

For your privacy, your medical chart and personal information is retained for 2 years and then destroyed. For a detailed overview of our privacy policies please visit our website www.healthstandnutrition.com or ask your dietitian for a copy of our privacy policies.

Initials

Client Name: _____

Client Signature: _____

Date: _____

Acknowledgement & Waiver



This MUST be read and signed before your dietitian can start working with you.

I hereby grant permission for Health Stand Nutrition Consulting Inc. to correspond with my physician(s), other health professionals and others as noted¹, to obtain and exchange information relevant to my nutrition treatment and counseling. I acknowledge that any information so obtained or disclosed will be held in strict confidence. I further acknowledge the information provided to me by Health Stand Nutrition Consulting Inc. is designed to meet my personal dietary needs. It is NOT suitable for any other individual and will not be transferred, copied or sold to another person.

In order to benefit from the treatment prescribed by Health Stand Nutrition Consulting Inc., I realize that it is important for me to inform either my physician and/or Health Stand Nutrition Consulting Inc. of any changes I make in the application of my diet. It is my responsibility to report any side effects or problems immediately and to make the necessary adjustments to my treatment plan with my physician and/or Health Stand Nutrition Consulting Inc. I will not hold Health Stand Nutrition Consulting Inc. responsible for any complications, which result from my failure to comply with either of the above. All recommendations (verbal, written, audio, internet and email) provided by Health Stand Nutrition Consulting Inc. are intended for educational and informational purposes only. The information provided is not a substitute for a professional medical opinion. Please contact your doctor for specific individualized health and nutrition recommendations. Health Stand Nutrition Consulting Inc. and its employees, consultants, authors and publishers disclaim any liability in connection with the use of the information.

1 Others As Noted

I hereby grant Health Stand Nutrition Consulting Inc. permission to share my personal information, relevant to the nutrition treatment and counseling that I receive from Health Stand Nutrition Consulting Inc., with the following individuals identified as “others as noted”.

If applicable, please print the name and identify the relationship to the Client, otherwise strike through this section of the Acknowledgment and Waiver indicating “not applicable”.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Client Name: _____

Client Signature: _____

Date: _____