

QUESTIONNAIRE NCQ006

Last printed: 2005-06-14 (20:28:00)

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CHILD NUTRITION QUESTIONNAIRE

First Name: _____ Surname: _____

Address _____

Postcode: _____ Telephone _____

e-Mail: _____

GP's name: _____

I heard about your services from: _____

Consultant's Name (if undergoing specialist investigation/supervision): _____

Hospital Name: _____

Date of Birth (DOB): _____

Weight: _____ Height: _____

CURRENT HEALTH PROBLEMS AND CONCERNS:

PROBLEM	DURATION (from, to + if current)	TRIGGERS (if identifiable) +/- or Influences	TREATMENT TRIED (orthodox/alternative remedies) incl. dosage of medicines

If you require clarification concerning the information outlined above please contact your nearest qualified nutritional therapist for an appointment or contact: Ursula Fearn, MSc. Dip. ION BANT — Telephone: (01620) 826810, (07810) 673565 or (0131) 225 8092 or email: ursula@nutri-ception.co.uk (website: www.nutri-ception.co.uk).

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FAMILY HEALTH PROFILE

Please state any illnesses or allergies suffered by family members below, in the space below:

Mother: _____

Father: _____

Sister: _____

Brother: _____

Maternal grandparents: _____

Paternal grandparents: _____

FEEDING + WEANING

Was/is your child breast fed? yes/no. Age stopped breast feeding: _____

Was/is your child bottle fed? yes/no. If yes, please state formula: _____

Age began weaning: _____

State order of food introduction, give months of age beside food: _____

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

Age introduced to: milk: _____ months, eggs: _____ months.

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MOTHER'S PROFILE

I smoked whilst pregnant or breast feeding (please tick box).

I drank alcohol whilst pregnant or breast feeding (please tick box).

I drank coffee and/or tea whilst pregnant or breast feeding (please tick box).

I had medical tests whilst pregnant . Please state: _____

I had thrush , cystitis whilst pregnant or before.

If yes please state date of last thrush/cystitis: _____

Was thrush treated? yes/no — Treatment used: _____

Do or did you suffer from postnatal depression? yes/no

If yes, please state treatment used: _____

Additional info: _____

PREGNANCY PROFILE

Assisted pregnancy or infertility treatment? yes/no

Duration: _____ Premature: _____ On time: _____

Abnormalities during pregnancy e.g. gestational, diabetes, bleeding, sickness, cravings, high blood pressure, pre-eclampsia, etc. If yes, treatment received: _____

Additional info: _____

BIRTH PROFILE

Normal , forceps or Caesarean — length of labour: _____ birth weight: _____

Country of birth: _____

The baby suffered from jaundice , stress , oxygen deficit , zinc deficit .

Additional info: _____

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SYMPTOM PROFILE

Please tick any symptoms below that your child or baby is experiencing:

- | | | |
|---|--|---|
| <input type="checkbox"/> Excessive wind | <input type="checkbox"/> Rash | <input type="checkbox"/> Aggression |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Ear ache | <input type="checkbox"/> Excessive crying |
| <input type="checkbox"/> Diarrhoea | <input type="checkbox"/> Frequent colds + infections | <input type="checkbox"/> Bed wetting |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Nappy rash | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Colic | <input type="checkbox"/> Cradle cap | <input type="checkbox"/> Phobias |
| <input type="checkbox"/> Poor appetite | <input type="checkbox"/> Thrush | <input type="checkbox"/> Sweet/sweet food addiction |
| _____ | <input type="checkbox"/> Whooping cough | _____ |
| <input type="checkbox"/> Thread worms | _____ | <input type="checkbox"/> Cleft palate |
| <input type="checkbox"/> Scabies | <input type="checkbox"/> Down's syndrome | <input type="checkbox"/> Eczema or dermatitis |
| <input type="checkbox"/> Coeliac disease | <input type="checkbox"/> Arthritis (Still's disease) | <input type="checkbox"/> Cystic fibrosis |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Sickle cell anaemia | <input type="checkbox"/> Haemophilia |
| <input type="checkbox"/> Muscular dystrophy | <input type="checkbox"/> Phenylketonuria | <input type="checkbox"/> Diabetes |
| _____ | <input type="checkbox"/> Heart disease or defects | _____ |
| <input type="checkbox"/> Nose bleeds | _____ | |
| <input type="checkbox"/> Conjunctivitis | <input type="checkbox"/> Hyperactivity | |
| <input type="checkbox"/> Growing pains | <input type="checkbox"/> Short attention span | |

PERSONALITY PROFILE

Please tick any of the behavioural descriptions below that match your child or baby:

- | | | | |
|--------------------------------------|--|-----------------------------------|--|
| <input type="checkbox"/> Content | <input type="checkbox"/> Excitable | <input type="checkbox"/> Restless | <input type="checkbox"/> Head Banging |
| <input type="checkbox"/> "Very Good" | <input type="checkbox"/> Discontent | <input type="checkbox"/> Tough | <input type="checkbox"/> "All over the Place" |
| <input type="checkbox"/> Wide Awake | <input type="checkbox"/> Aggressive | <input type="checkbox"/> Nervous | <input type="checkbox"/> Learning Difficulties |
| <input type="checkbox"/> Very "Neat" | <input type="checkbox"/> Irritable | <input type="checkbox"/> Rocking | |
| <input type="checkbox"/> Impulsive | <input type="checkbox"/> a "Holy Terror" | <input type="checkbox"/> Clumsy | |

IMMUNISATION HISTORY

DATE	TYPE	REACTION (If any)

ANY ADDITIONAL INFORMATION YOU WOULD LIKE TO GIVE (use back of sheet):

THIS QUESTIONNAIRE ACKNOWLEDGES THE WORK OF SALLY CHILDS Dip. ION
 (Nutritional Consultant Specialising in Child Health Issues)

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