Diabetes & Nutrition Teaching Center
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Pediatric Nutrition Self-Assessment

To be completed by patient/guardian, Signature: _____
Date:_____ Doctor who referred you: _____

1. Demographics:
Name_____
Date if Birth:_____ Age: _____Years _____months

Parent/Guardian Name: _____
Relationship of Guardian to patient: _____
Address _____
Current Phone Numbers: _____(Home) _____(Work) _____(Cell)

Gender: ___ female ___ male
Race: ___Caucasian ___African American ___Hispanic ___Asian ___ American Indian/Eskimo ___Other
Religion: ___ Catholic ___ Protestant ___ Jewish ___ Other

2. Medical History
Does child or caregiver have any barriers to learning/special education needs? ___ Yes ___ No
If yes: ___ Visual ___ Hearing ___Literacy ____ Other _____

Does your child have any of the following medical conditions?
Yes ___No___ Diabetes
If so, any previous Diabetes Education: ___Yes ___No When: _____
Where: _____

Type1
Insulin Dose:_____
Meter Brand:_____
Lowest/highest blood sugar over the past week:_____
Last Hgb A1C value:_____

Type 2
Medications:_____
Meter Brand:_____
Lowest/highest blood sugar over the past week:_____
Last Hgb A1C value:_____

Do you have:
___ Yes ___No Asthma
___ Yes ___No ADHD
___ Yes ___No Depression
___ Yes ___No Sleep Apnea
If yes, does your child use a CPAP machine? ___Yes ___No
Does your child snore? ___Yes ___No
Does your child fall asleep during the day or at school? ___Yes ___No
Does your child have problems with bedwetting? ___Yes ___No
___ Yes ___No Hyperinsulinemia (Too much insulin production)
___ Yes ___ No Insulin resistance (Body's cells resistant to the action of insulin)
___ Yes ___ No Acanthosis Nigricans (Dark brown discoloration of the neck)

Pediatric Nutrition Self-Assessment-Continued…

___ Yes ___ No High Blood Pressure
___ Yes ___ No High Cholesterol
___ Yes ___ No High Triglycerides
___ Yes ___ No Numbness, pain, burning
___ Yes ___ No Frequent Urination
___ Yes ___ No Chronic Constipation
___ Yes ___ No Eye Problems
___ Yes ___ No Bone/Joint Problems
If yes, what type of problem _____
Is your child receiving treatment for this problem? ___Yes ___No
If so, what kind of treatment?_____

Other: (list) _____
List any surgeries: _____

List all medications: _____
Do you take vitamin/mineral pills? ___ Yes ___ No If yes, list: _____

Does your child have any allergies?
Food_____ Environment_____ Medication_____ Other_____
If yes, please explain: _____

Do you currently have any concerns regarding your child's health? ___Yes ___No
If yes, please comment:_____

Who does the patient spend most of his/her time with?_____
Where does the patient eat most meals and snacks when not in school?_____
How is the best way to provide health and nutrition education?
___Verbal ___Written handouts ___Pictures ___Other (explain:_____)

3. School Information

School: _____
Grade: _____ Homeroom Teacher:_____
School Nurse:_____
Approve for School Nurse to measure height, weight, and BMI at school? ___Yes ___No
How are you child's grades? ___Great ___Good ___Fair ___Poor ___Failing grade
Does your child receive a special diet at school? ___Yes ___No
Does your child receive free or reduced meals at school? ___Yes ___No
Which meals does your child eat at school? ___Breakfast ___Lunch
Do any of the following apply to your child? ___Skips meals ___Purchase extra food in the cafeteria
___Carries lunch from home ___Other (Explain:_____)

4. Psychosocial Information

Some people gain weight because something serious or upetting has happended in their family or to them. Please check if any of these things has happened in your family and note how old your child was when they happened.

			Comments
Divorce	___Yes (Age:___)	___No	_____
Father remarries	___Yes (Age:___)	___No	_____
Mother remarries	___Yes (Age:___)	___No	_____
Change homes(Move)	___Yes (Age:___)	___No	_____
Change schools	___Yes (Age:___)	___No	_____

Pediatric Nutrition Self-Assessment-Continued…

Family member incarcerated ___Yes (Age:___) ___No _____
Death of a close family member ___Yes (Age:___) ___No _____
Death of a favorite pet ___Yes (Age:___) ___No _____
Other: _____

5. Environment

Resource for food:

___Food Stamps ___WIC ___Food Bank/Church Pantry Ministry
___Farmers' Market ___Home garden ___Other (Explain:_____)
Where is the majority of grocery shopping done? (Store name) _____
How often to you grocery shop? _____
Who does most of the grocery shopping?_____
Do you feel you have adequate funds for food? _____Yes _____No

Transportation:

_____Own Vehicle _____Bus/Public transportation _____Van service
_____Taxi _____Neighbor _____Relative
_____Walk _____Bicycle

6. Lifestyle Habits

Some lifestyle habits can contribute to excessive weight gain. Which habits does your child have?

Eat in front of TV, computer, video games	___Yes ___No
Eat while talking on phone	___Yes ___No
Eat when others are not watching	___Yes ___No
Vomits after eating too much	___Yes ___No
Takes laxatives after eating too much	___Yes ___No
Eats when bored	___Yes ___No
Eats more than 1 serving at a meal or snack	___Yes ___No
Eats snacks at unplanned times ("grazing")	___Yes ___No
Eats when friends put pressure on him/her	___Yes ___No
Has television in bedroom	___Yes ___No
Sleeps less than 8 hours per night	___Yes ___No
If less than 8 hours, how many hours?_____	
Has greater than 2 hours of screen time daily	___Yes ___No
If yes, how many hours daily?_____	
Eats at least one meal a day as family seated together at a table	___Yes ___No
If no, where are meals eaten?_____	

How do you reward your child for his/her accomplishments?_____

Activity and exercise can have an effect on your child's weight. Please check which habits your child has:

Play sports (basketball, soccer, softball, etc.) ___Yes ___No
If yes, how often?_____
Exercises (run, fast walk, swim, dance, etc.) ___Yes ___No
If yes, how often?_____
Toning exercise (sit ups, toe touches, leg lifts, etc.) ___Yes ___No
If yes, how often?_____
If your child has an afternoon of free time, what would he/she do?_____