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| **DIET HEALTH & LIFESTYLE****QUESTIONNAIRE** FOR BABIES & CHILDREN | HEALD NUTRITION Personalised dietary advicefor health & Wellbeing |

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| This questionnaire is designed to provide us with the information on your child’s diet health & lifestyle required to create a personalised nutritional programme specifically tailored for their needs. All information provided is treated in the strictest confidence. Please answer the questions as fully as possible (using the additional sheets provided if necessary), and return the completed questionnaire to charlotte@healdnutrition.co.uk or Napiers clinic (18 Bristo Place, Edinburgh EH1 1EZ) at least 3 days before your appointment. |

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| OFFICE USE ONLY |
| DATE |  |
| REF |  |

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| CHILD’S NAME |  | DOB |  | AGE |  | [ ]  M [ ]  F |
| PARENT / CARER’S NAME |  |
| ADDRESS |  |
| EMAIL |  | HOME TEL |  | MOBILE |  |
| GP NAME & ADDRESS |  |
| OTHER HEALTH PROFESSIONALS / THERAPISTS INVOLVED IN YOUR CHILD’S CARE: |
| HOW DID YOU HEAR ABOUT HEALD NUTRITION? |
|  |
| **HEALTH PROFILE** |
|  |
| WHAT IS YOUR MAIN REASON FOR SEEKING NUTRITIONAL ADVICE FOR YOUR CHILD? |
| WHAT HEALTH OUTCOMES ARE YOU HOPING TO ACHIEVE FOR YOUR CHILD? |
| HEIGHT |  | WEIGHT |  |  |
|  |
| **MAIN HEALTH ISSUES****PLEASE LIST YOUR CHILD’S HEALTH ISSUES THAT YOU WOULD LIKE TO FOCUS ON:** |
| HEALTH ISSUE (EG DIGESTIVE PROBLEMS ALLERGIES, ECZEMA) | MANAGEMENT SO FAR (GP DIAGNOSIS, MEDICATION, OPERATIONS) | ONSET / DURATION |
| 1. |  |  |
| 2. |  |  |
| 3. |  |  |

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| HAS YOUR CHILD HAD ANY RECENT HEALTH TESTS? IF YES, PLEASE SPECIFY & GIVE RESULTS: |
| HAS YOUR CHILD HAD ANY OTHER DIAGNOSED CONDITIONS, MAJOR SURGERY, SIGNIFICANT PERIODS OF ILL HEALTH OR SUFFER FROM CHRONIC OR NIGGLING HEALTH PROBLEMS (EG FREQUENT COUGHS AND COLDS)? IF YES, PLEASE GIVE DETAILS |
| DO YOU SUSPECT YOUR CHILD’S HEALTH CONCERNS RELATE TO A PARTICULAR EVENT OR TIME IN THEIR LIFE? |
|  |
| **MEDICATION** |
| **PLEASE LIST ANYTHING YOUR CHILD TAKES REGULARLY** **(EG PRESCRIBED MEDICATION, OVER THE COUNTER MEDICATION, SUPPLEMENTS & HERBAL REMEDIES)** |
| MEDICATION | REASON FOR TAKING / CONDITION | DOSE | FREQUENCY / DURATION |
|  |  |  |  |
| HAS YOUR CHILD EVER TAKEN ANTIBIOTICS? IF YES, WHEN AND FOR HOW LONG? |
| HAS YOUR CHILD RECEIVED THE RECOMMENDED STANDARD IMMUNISATIONS? |
|  |
| **FAMILY DETAILS** |
|  |
| **MOTHER** | NAME: | AGE: | OCCUPATION: |
| BIRTH MOTHER? | Y / N | SIGNIFICANT HEALTH PROBLEMS: |
| **FATHER** | NAME: | AGE: | OCCUPATION: |
| GENETIC FATHER? | Y / N | SIGNIFICANT HEALTH PROBLEMS: |
| **SIBLINGS** |
| BROTHER / SISTER | AGE | SIGNIFICANT HEALTH PROBLEMS |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
| ARE THERE ANY ILLNESSES OR CONDITIONS THAT YOUR OTHER FAMILY MEMBERS MAY SUFFER FROM?(EG HEART DISEASE, DIABETES, ALLERGIES, ASTHMA) |
| YOUR PARENTS: | YOUR SIBLINGS: |

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| **PREGNANCY DETAILS** |
| **PLEASE COMPLETE THIS PAGE IF YOUR CHILD IS 4 YEARS OR YOUNGER** |
| DID YOU EXPERIENCE DURING YOUR PREGNANCY: |
| DID YOU SUFFER ANY ILLNESSES AND / OR PREGNANCY RELATED CONDITIONS DURING YOUR PREGNANCY (E.G. INFECTIONS, OPERATIONS)? IF YES, PLEASE GIVE DETAILS  |
| DID YOU RECEIVE ANY TREATMENTS FOR ANY OF THE ABOVE? IF YES, PLEASE GIVE DETAILS |
| PLEASE GIVE DETAILS OF MEDICAL TESTS DONE DURING PREGNANCY (EG SCANS, BLOOD TESTS) |
| DID YOU TAKE ANY OF THE FOLLOWING DURING YOUR PREGNANCY? PLEASE STATE HOW MUCH AND AT WHAT STAGE |
|  | AMOUNT | STAGE  |  |  | AMOUNT | STAGE  |
| TEA  |  |  |  | ALCOHOL |  |  |
| COFFEE |  |  |  | CIGARETTES |  |  |
| NUTRITIONAL SUPPLEMENTS |  |  |  | MEDICATIONS (PRESCRIBED, OVER THE COUNTER) |  |  |
|  |
| ANY ADDITIONAL SIGNIFICANT INFORMATION REGARDING YOUR PREGNANCY? |
|  |
| **DIET DURING PREGNANCY** |
| DID YOU CHANGE YOUR DIET DURING PREGNANCY? IF YES, PLEASE GIVE DETAILS |
| DID YOU CRAVE ANY FOODS / NON FOODS? |

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| **BIRTH DETAILS & EARLY DEVELOPMENTAL HISTORY** |
|  |
| TYPE OF BIRTH:[ ]  NORMAL VAGINAL DELIVERY [ ]  FORCEPS / VENTOUS [ ]  PLANNED CAESARIAN [ ]  EMERGENCY CAESARIAN |
| MEDICATIONS / INTERVENTIONS DURING LABOUR:[ ]  WATER BIRTH [ ]  INDUCED [ ]  GAS & AIR [ ]  PETHEDINE [ ]  EPIDURAL [ ]  TENS MACHINE [ ]  SPINAL BLOCK |
|  |
| LENGTH OF LABOUR (HOURS):  |  | BIRTH WEIGHT: |
|  |
| DID YOUR BABY REQUIRE SPECIAL CARE? IF YES, PLEASE GIVE DETAILS |
| HAS YOUR GP, HEALTH VISITOR OR ANY OTHER MEDICAL PRACTITIONER EVER EXPRESSED CONCERN REGARDING YOUR CHILD’S DEVELOPMENT (EG SPEECH, LEARNING, WALKING, HEARING)? IF YES, PLEASE GIVE DETAILS: |
| HAS YOUR CHILD’S GROWTH PATTERN BEEN ‘NORMAL’ (EG HEIGHT, WEIGHT, GROWTH CENTILE)? |
|  |
| **EDUCATION / CHILD CARE / ACTIVITIES** |
|  |
| DOES YOUR CHILD ATTEND:[ ]  DAY NURSERY [ ]  CHILD MINDER [ ]  PLAYGROUP [ ]  PRE-SCHOOL NURSERY [ ]  SCHOOL |
| NAME OF NURSERY / PLAYGROUP / SCHOOL: |
| DAYS PER WEEK THAT CHILD ATTENDS: |
| DOES YOUR CHILD TAKE PART IN ANY CLASSES / ACTIVITIES (EG FOOTBALL, SWIMMING LESSONS, BALLET)? IF YES, PLEASE GIVE DETAILS |
| HOW MUCH EXERCISE DOES YOUR CHILD HAVE IN A WEEK? |
| ON AVERAGE HOW MANY HOURS DOES YOUR CHILD WATCH TELEVISION / USE A COMPUTER EACH DAY? |
|  |
| **DIGESTION** |
|  |
| DOES YOUR CHILD REGULARLY EXPERIENCE: |
| FREQUENT STOMACH UPSETS | Y / N |  | CONSTIPATION | Y / N |
| STOMACH PAINS / CRAMPS | Y / N | DIARRHOEA  | Y / N |
| NAUSEA AND/OR VOMITING | Y / N | BLOOD / MUCUS / FOOD IN STOOLS | Y / N |
| BLOATING / EXCESSIVE WIND | Y / N | ITCHY BOTTOM | Y / N |
|  |
| HOW OFTEN DOES YOUR CHILD HAVE A BOWEL MOVEMENT? |
|  |
| IS YOUR CHILDS URINE: [ ]  COLOURLESS [ ]  PALE YELLOW [ ]  DARK YELLOW [ ]  SMELLY [ ]  CLOUDY [ ]  OTHER COLOUR …………………..  |
| DO ANY FOODS CAUSE YOUR CHILD DIGESTIVE PROBLEMS, IF SO WHICH ONES? |

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| **SYMPTOM CLUSTERS** |
| **PLEASE CIRCLE OR UNDERLINE ANY CONDITIONS THAT YOU REGULARLY EXPERIENCE** |
| HEADHeadaches Earache Excess mucous Head banging / rocking Tooth decay Mouth ulcers Cold sores Recurrent tonsillitis Sore throat Frequent nose bleeds Sneezing Congested nose Runny nose Sinusitis Rhinitis Hay fever Prone to snoring | CHESTFrequent colds & chest infections Asthma Noisy breathing Wheezing Difficulty breathing Persistent cough |
| SKINDry Rough Flaky Scaly Oily Clammy Puffy Pale Slow to heal |
| CHILD’S PERSONALITY / BEHAVIOURContented Well behaved Wide awake Tidy Messy Clumsy Nervous Unhappy Temper tantrums Impulsive Excitable Nail biter Irritable Restless Tough Physical Emotional Plays well alone Easily distracted Learning difficulties Agile ‘Gifted’ child Lazy Lethargic Sleepy Popular Sociable Affectionate Rejects affection Good listening ears |
| SKIN PRONE TOEczema Dermatitis Psoriasis Acne Pimples Rashes Hives Itching Allergic reactions Easy bruising Ringworm |
| HANDSDry Cracked Eczema Puffy Sore joints Cold Numbness Poor circulation Tingling Chilblains Clumsy & uncoordinated |
| STOMACHPainful Tender Cramping Nausea Vomiting Churning Gastroenteritis Frequent stomach bugs Bloated Distended Sensation of fullness Sluggish Flatulence Sensitive Coeliac Ulcers Constipation Diarrhoea Food allergies / sensitivities Painful or frequent urination Frequent toilet accidents Bed wetting  |
| SPECIFIC CONDITIONSDyslexia Dyspraxia Cerebral Palsy ADHD Autism Autism spectrum disorder Asperger’s syndrome Epilepsy Crohn’s Disease Phenylketonuria Downs syndrome Cleft palate Heart disease Sickle cell anaemia Cystic fibrosis Diabetes |
|  |
| **IMPORTANT SYMPTOMS**PLEASE INDICATE BY UNDERLINING IF YOUR CHILD SUFFERS FROM ANY OF THE FOLLOWING SYMPTOMS WHICH MAY REQUIRE ADDITIONAL MEDICAL CARE:Persistent / unexplained pain Unexplained bleeding or discharge Blood in sputum / vomit / urine / stools Difficultly swallowing Excessive thirst Increased urination Inability to gain / lose weight Loss of appetite Unexplained bruising / rash / weight Loss Black tarry stools |

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| **EATING HABITS** |
|  |
| DO / DID YOU BREAST FEED YOUR CHILD? IF YES, FOR HOW LONG? |
| IF YOU BREAST FEED / FED: |
| DO / DID YOU TAKE ANY OF THE FOLLOWING WHILST BREASTFEEDING? [ ]  CAFFIENE [ ]  CIGARRETTES [ ]  ALCOHOL |
| DO / DID YOU TAKE ANY MEDICATIONS / SUPPLEMENTS / REMEDIES WHILST BREAST FEEDING? IF YES, PLEASE GIVE DETAILS |
| DO / DID YOUR BOTTLE FEED YOUR CHILD? IF YES, FROM WHAT AGE AND WHAT TYPE OF FORMULA? |
| HOW OLD WAS YOUR CHILD WHEN YOU STARTED WEANING ONTO SOLIDS? |
| DID YOUR CHILD HAVE ANY REACTIONS TO ANY FOOD WHEN BEING INTRODUCED TO THEM (IE WHEAT, COW’S MILK, EGGS)? |
|  |
| WOULD YOU DESCRIBE YOUR CHILD’S APPETITE AS: [ ]  EXCESSIVE [ ]  GOOD [ ]  MEDIUM [ ]  POOR |
| IS YOUR CHILD A FUSSY EATER? |
| WHAT ARE YOUR CHILD’S FAVOURITE FOODS? |
| ARE THERE ANY FOODS THAT YOUR CHILD DISLIKES? |
| IS YOUR CHILD CURRENTLY FOLLOWING A SPECIFIC DIETARY REGIME (EG GLUTEN / WHEAT FREE, DAIRY FREE)? IF YES, PLEASE GIVE DETAILS |
| DOES YOUR CHILD EAT AT NURSERY / SCHOOL? IF YES, HOW MANY TIMES A WEEK: |
| DOES YOUR CHILD TAKE A LUNCH BOX TO NURSERY / SCHOOL? IF YES, HOW MANY TIMES A WEEK: |
| DOES YOUR CHILD REGULARLY EAT ORGANIC: | [ ]  FRUIT [ ]  VEGETABLES [ ]  MEAT [ ]  DAIRY |
| WHAT TYPE OF BREAD, RICE AND PASTA DOES YOUR CHILD USUALLY EAT? | **BREAD:**  | [ ]  WHITE [ ]  BROWN [ ]  WHOLEMEAL [ ]  GRANARY |
| **PASTA:** | [ ]  WHITE [ ]  WHOLEMEAL |
| **RICE:**  | [ ]  WHITE [ ]  BROWN [ ]  WILD |
| HOW MANY TIMES A WEEK DOES YOUR CHILD EAT: |
| RED MEAT (BEEF LAMB PORK GAME) |  |  | CHOCOLATE / SWEETS |  |
| PROCESSED MEATS (HAM BACON SAUSAGES HAMBURGERS) |  |  | PUDDINGS |  |
| WHITE MEAT (CHICKEN TURKEY) |  |  | CAKES / BISCUITS |  |
| WHITE FISH (COD HADDOCK POLLOCK) |  |  | READY MEALS |  |
| OILY FISH (SALMON TROUT TUNA HERRING MACKEREL) |  |  | TAKE AWAYS / FAST FOOD |  |
| FRIED FOODS |  |  | CANNED / FIZZY / SUGARY DRINKS |  |

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| **3 DAY FOOD DIARY** |
| PLEASE CHOOSE 2 FAIRLY TYPICAL WEEKDAYS AND A WEEKEND / DAY OFF AND RECORD BELOW WHAT YOUR CHILD ATE AND DRANK.PLEASE GIVE AS MUCH INFORMATION AS POSSIBLE – EG PORTION SIZE, HOME COOKED (IF SO PLEASE STATE INGREDIENTS) OR SHOP BOUGHT, BRAND NAMES, FRESH, ORGANIC, WHOLEGRAIN / WHOLE WHEAT OR WHITE ETC |
|  | WEEKDAY 1 | WEEKDAY 2 | WEEKEND DAY / DAY OFF |
| BREAKFAST | TIME / PLACE\*: | TIME / PLACE\*: | TIME / PLACE\*: |
| LUNCH | TIME / PLACE\*: | TIME / PLACE\*: | TIME / PLACE\*: |
| DINNER | TIME / PLACE\*: | TIME / PLACE\*: | TIME / PLACE\*: |
| SNACKS | TIME / PLACE\*: | TIME / PLACE\*: | TIME / PLACE\*: |
| DRINKS | GLASSES OF WATER |  | GLASSES OF WATER |  | GLASSES OF WATER |  |
| MILK |  | MILK |  | MILK |  |
| FRESH FRUIT JUICE / SMOOTHIES |  | FRESH FRUIT JUICE / SMOOTHIES |  | FRESH FRUIT JUICE / SMOOTHIES |  |
| FIZZY DRINKS / CORDIALS |  | FIZZY DRINKS / CORDIALS |  | FIZZY DRINKS / CORDIALS |  |
| OTHER DRINKS: |  | OTHER DRINKS: |  | OTHER DRINKS: |  |

\* PLACE = HOME / NURSERY / SCHOOL / OTHER

 **TERMS OF ENGAGEMENT** (Issue 2.2 Dec 2012)

BETWEEN THE BANT NUTRITIONAL THERAPIST (NT) AND HIS/HER CLIENT

Please read and then sign and date the form below. If you have any queries please contact me.

**The Nutritional Therapy Descriptor**

Nutritional Therapy is the application of nutrition science in the promotion of health, peak performance and individual care. Nutritional therapy practitioners use a wide range of tools to assess and identify potential nutritional imbalances and understand how these may contribute to an individual's symptoms and health concerns. This approach allows them to work with individuals to address nutritional balance and help support the body towards maintaining health.

Practitioners consider each individual to be unique and recommend personalised nutrition and lifestyle programmes rather than a 'one size fits all' approach. Practitioners never recommend nutritional therapy as a replacement for medical advice and always refer any client with 'red flag' signs or symptoms to their medical professional. They will also frequently work alongside a medical professional and will communicate with other healthcare professionals involved in the client's care to explain any nutritional therapy programme that has been provided.

**The Nutritional Therapist (NT) requests that the Client notes the following:**

* The degree of benefit obtainable from Nutritional Therapy may vary between clients with similar health problems and following a similar Nutritional Therapy programme.
* Nutritional advice will be tailored to support health conditions and/or health concerns identified and agreed between both parties.
* Nutritional therapists are not permitted to diagnose, or claim to treat, medical conditions.
* Nutritional advice is not a substitute for professional medical advice and/or treatment.
* Your Nutritional Therapist may recommend food supplements and/or functional testing as part of your Nutritional Therapy programme and may receive a commission on these products or services.
* Standards of professional practice in Nutritional Therapy are governed by the CNHC Code of Conduct.
* This document only covers the practice of Nutritional Therapy within this consultation, and your practitioner will make it clear if he or she intends to step outside this boundary.

**The Client understands and agrees to the following:**

* I am responsible for contacting my child’s GP about any health concerns.
* I give permission for you to contact my child’s GP regarding any agreed aspects of my child’s case: [ ]  YES [ ]  NO
* If my child is receiving treatment from his/her GP, or any other medical provider, I should tell him/her about any nutritional strategy provided by my child’s nutritional therapist. This is necessary because of any possible reaction between medication and the nutritional programme.
* It is important that I tell my child’s nutritional therapist about any medical diagnosis, medication, herbal medicine, or food supplements my child is taking, as this may affect the nutritional programme.
* If I am unclear about the agreed nutritional therapy programme/food supplement doses/time period, I should contact my child’s nutritional therapist promptly for clarification.
* I must contact my child’s nutritional therapist should I wish to continue any specified supplement programme for longer than the original agreed period, to avoid any potential adverse reactions.
* Recording consultations using any form of electronic media is not allowed without the written permission of both me and my child’s nutritional therapist.

**We understand the above and agree that our professional relationship will be based on the content of this document. We declare that all the information we share during this professional relationship is confidential and to the best of our knowledge, true and correct.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| CLIENT & PARENT’S NAME: |  |  | NT NAME: |  |
| PARENT’S SIGNATURE: |  |  | NT SIGNATURE: |  |
| DATE: |  |  | DATE: |  |

**CONSENSUAL AGREEMENT BETWEEN BANT MEMBER PRACTITIONER AND PARENT/GUARDIAN OF CHILD UNDER 16 YEARS**

A BANT Member Practitioner is not permitted to advise or consult with clients under sixteen years of age without their parent or guardian being present and without the written consent of the parent/guardian.

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ being the parent/guardian (delete as applicable)

of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Name of Client) do hereby give my consent

for Charlotte Heald to consult with and advise the above named client.

Parent/guardian name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NT name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NT Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **ADDITIONAL INFORMATION** |
| **IF NECESSARY, PLEASE USE THIS SHEET TO CONTINUE YOUR ANSWERS** |
|  |