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Adolescent Nutrition Information Form

Date _____
Parent Name _____ Parent e-mail _____
Parent phone _____ Cell phone _____
Address: _____

Patient Name: _____ Date of Birth _____

Reason for requesting nutrition consultation:

Referring physician _____

Patient's most recent Weight _____ Height _____ BMI(2-20 years) _____

Any recent weight gain or loss in the last year? _____ How much? _____

Weight history: Any issues/concerns with overweight, underweight and/or growth in height during infancy and childhood? Please describe: _____

Sleep: hours per night _____ Any difficulties _____

Were there any life changes around that time? (e.g. illness/death of family member, divorce, move, change in school, etc) _____

Health History:

Current and former health concerns and year of onset and duration (use additional sheet if necessary):

Medications: _____

Nutritional Supplements: _____

Food allergies/intolerances? _____

Patient typical physical activity: What types (sports, playing outside, active play inside...)?

How many hours per day and days per week? _____

Patient sedentary activities (TV, Computer time, DVD's, Video games, cell phone games/texting, etc) what and how many hours/day or week? _____

