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Pediatric Nutrition Information Form

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

Child's Name: _____ Date of Birth _____

Reason for requesting nutrition consultation:

Referring physician _____

Your child's most recent Weight _____ Height/Length _____

BMI(2-20 years) _____ weight for length ratio (0-2 years) _____ %ile

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

Weight history: birth weight _____ Any issues/concerns with weight gain or growth in infancy? Please describe:

Weight percentiles for age: 0-1 years _____, 1-5 years: _____ 6-10 years _____

Please describe any changes in or concerns about weight gain or growth since infancy (e.g., increase or decrease in percentile channel) _____

If concerns about weight gain (high or low), when did they start?

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? _____
