KINETIC KIDS, INCORPORATED
Occupational Therapy, Physical Therapy,
Speech Language Pathology and Consulting Services
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Dietary History

Name of Child: ________________________________

1. How long did the client breast feed?
   __________months/years
   __________currently nursing
   __________not breast fed

2. During the period he/she was breastfeeding, did his/her mother experience any symptoms related to her breast such as burning, itching or pain of the breast tissue, sore nipples more than seven days after birth, plugged ducts or mastitis (breast infection)? If so, please describe:
   ____
   ____
   ____

3. What formulas did he/she take? ____

4. At what age did he/she start formula? ____

5. When did he/she first begin to take solid foods? ____

6. Is he/she currently taking vitamins, Yes or No?

   If so, what type ______________________________________

7. Does he/she take any other nutritional supplements? If so, what are they?
   ____
   ____

8. Please describe his/her current diet (i.e. favorite foods, pattern for meals,)

   ____
   ____

9. How often does he/she have a bowel movement? ____

   What are they like? ____

10. Does he/she have any symptoms from eating any particular food (i.e. food sensitivities)?
    ____

11. Does your child have any other dietary concerns you would like to share?
    ____
    ____
    ____