Brain Food Confidential New Patient Questionnaire

Please complete and submit this form at least three working days prior to your initial consultation with Jenny Edelstein. Any questions that do not apply to your child may be left blank. The questionnaire takes approximately 15 minutes to complete.

Personal details

Name of child:

Date of birth:

Address:

Telephone number:

Mobile number:

Email address:

Family details

Name of mother:

Age of mother:

Profession of mother:

Does mother have any significant health problems?

Name of father:

Age of father:

Profession of father:

Does father have any significant health problems?

Names and ages of siblings:

Do siblings have any significant health issues?

Do siblings have any significant developmental difficulties?

What languages are spoken at home?

Pregnancy and infancy

Any complications during pregnancy?

Vaginal birth or C-Section?

Was it a difficult birth?

Premature/late?

Weight and length of child at birth:

Was your child breastfed and if so how long?

Did your child have reflux as a baby?

At what age did your child start on solid foods?

Any ear infections in the first two years of life, and if so how many?

Approximately how many times did your child take antibiotics in the first two years of life?

Any operations or significant illnesses?

Did you follow the official immunization schedule? If not please describe.

Did your child react to any immunizations?

What percentile was your child for height and weight during his or her first two years?

Developmental history

At what age did your child stand?

Crawl?

Walk?

Speak first words?

Speak whole sentences?

Toilet trained?

At what point - if any - did you start to have concerns about your child's development?

What are your current concerns about your child's development?

Does your child have an diagnosis of a developmental disorder eg ASD? If so, please provide details of who gave the diagnosis and when.

Please circle any of the following that may apply to your child, and add comments where relevant:

poor sleeper

fussy eater

food cravings

passive

clumsy

loud

poor eye contact

prone to illness

frequently constipated

frequently bloated

bowel movements are liquid

bowel movements smell very bad

reflux

bad breath

dark circles under eyes

disruptive at school/nursery

violent

dreamy

sensitive to noise/touch/light/smell

sweet tooth

toileting accidents

“stimming”

frequent stomach aches

frequent headaches

distractable

Current health status

Current height and weight:

Is your child currently taking any medication? If so please provide details.

Does your child have any allergies?If so please provide details.

Any chronic illnesses eg asthma?

Any skin conditions eg eczema?

How often does your child miss school/nursery due to illness?

What are your current concerns regarding your child's health?

Education

What school or nursery does your child attend?

How would you describe your child's academic performance?

Does your child “fit in” socially?

Does your child have a statement or IEP?

Does your child receive any extra support at school?

Is your child receiving speech and language therapy, or any other therapies?

Eating habits

Does your child have any food allergies, to the best of your knowledge? If so please provide details.

What are your child's favourite foods?

Does your child crave certain foods? If so please provide details.

Is your child currently on a special diet? If so please provide details.

Does your child take any dietary supplements? If so please provide details.

What foods does your child dislike or refuse to eat?