Strong4Life℠ Pediatric Weight Management Nutrition Assessment Tool (for ages 0 to 2)

Children's℠ Healthcare of Atlanta

Visit date: MM|DD|YYYY Start time: _____ End time: _____ Visit #: _____

Patient name: _____ DOB: MM|DD|YYYY Age: _____

Parent/caregiver present: _____

Medical Dx: _____ Dx codes: _____

ASSESSMENT

Weight: _____ Length: _____ Head circumference: _____

Wt for stature %: _____ Wt for age %: _____ Stature for age %: _____

Goal(s) set at previous visit? (If applicable) _____

Goal(s) met? (If applicable) _____

Patient/caregiver reports: _____

Patient medical and weight history: _____

Pertinent family medical history: _____

Patient lab results: _____

Medications/vitamin/mineral supplements: _____

Food allergies/intolerances: _____

Developmental milestones: (Check all that apply)

- ☐ Opens mouth for breast/bottle
- ☐ Holds bottle without support
- ☐ Picks up food with fingers
- ☐ Drinks from bottle/sippy cup
- ☐ Sits up to eat
- ☐ Drinks from open mouth cup
- ☐ Brings objects to mouth/bites them
- ☐ Opens mouth for spoon
- ☐ Other: _____

Sources of iron, zinc, vitamin D, EFA: _____ (*Adequate*:)

Daily energy needs: _____ Kcal _____ grams protein _____ grams fat _____ grams carb _____ grams fiber

Food/beverage sources: (Check all that apply)

- ☐ Breastmilk (breast/bottle/cup) *How often:* _____ *Duration*: _____ *Any issues:* _____
- ☐ Formula *Type*: _____ *How often*: _____ *Amt*: _____
- ☐ Cow's milk *Type*: _____ *How often*: _____ *Amt*: _____
- ☐ Other milk *Type*: _____ *How often*: _____ *Amt*: _____
- ☐ Juice/sweet drinks *Type*: _____ *How often*: _____ *Amt*: _____
- ☐ Water *Source*: _____ *How often*: _____ *Amt*: _____
- ☐ Solid foods (*Since age*: _____) *Type(s)*: _____

Comments: _____

Reviewed intake log (If applicable): _____

Dietary History

Feeding time: With:	Feeding time: With:	Feeding time: With:	Feeding time: With:	Feeding time: With:	Feeding time: With:

Comments: _____

Infant/child eating behaviors: (Check all that apply)

- ☐ Alerts when full (*How*: _____)
- ☐ Alerts when hungry (*How*: _____)
- ☐ Carries bottle to bed/around house
- ☐ Drinks juice/sweet drinks
- ☐ Dislikes feeding time
- ☐ Seems discontent after feeding
- ☐ Eats a variety of flavors/textures
- ☐ Likes fruits/vegetables
- ☐ Dislikes fruits/vegetables
- ☐ Eats away from the table
- ☐ Other: _____
- ☐ Other: _____

Parent/caregiver feeding behaviors: (Check all that apply)

- ☐ Early introduction to solids
- ☐ Forces bottle/food/beverage intake
- ☐ Restricts bottle/food/beverage intake
- ☐ Eats together as a family
- ☐ Inconsistent meal planning
- ☐ Fast food/convenience foods
- ☐ Offers choking hazards
- ☐ Feeds same food family eats
- ☐ Dislikes feeding time w/child
- ☐ Distractions while eating
- ☐ Other: _____
- ☐ Other: _____

Physical activity/sedentary behaviors: (Check all that apply)

- ☐ Type(s) of activity: _____ (_____ days/wk) (_____ hrs./day)
- ☐ TV/screen time (_____ hrs./day)
- ☐ Naps during the day (_____ hrs./day)
- ☐ Sleeps at night (_____ hrs./night)

Comments: _____

NUTRITION DIAGNOSIS/PES STATEMENT (Behavior-focused)

_____ related to _____

_____ as evidenced by _____

Comments: _____

INTERVENTION

Nutrition/counseling topics covered: (Check all that apply)

- ☐ Breastfeeding
- ☐ Water intake
- ☐ Sugar demo/limit sugary drinks
- ☐ Introduction to solids
- ☐ Meal planning
- ☐ Ps and Cs
- ☐ Eating out/convenience foods
- ☐ Food groups (fruits/veggies/protein/grains/dairy)
- ☐ Plate method/portion sizes
- ☐ Screen time
- ☐ Active play
- ☐ Label reading
- ☐ Assigned intake log (photo/written/online/app)
- ☐ Other: _____
- ☐ Other: _____
- ☐ Other: _____

Comments: _____

Education materials/resources provided: _____

SMART Goals: **S**pecific, **M**easurable, **A**chievable, **R**ealistic and **T**imely

1) _____

2) _____

MONITORING & EVALUATION

Comments: _____

RDN signature: _____ Date: MM|DD|YYYY

Next visit date/time: MM|DD|YYYY Topic for next visit: _____