Pediatric Initial Consult Form

Name: _____

Age: Height: Weight:

Goals:

Weight Loss/Gain History:

Current Eating Habits/Diet at home:

Job/Activity Level/Workout Schedule:

Food Allergies/Intolerances:

Favorite Types of food:

Restaurants (how often, usual meal choice):

Typical Day:

Food Likes: **Dislikes:**

Fruits:

Veggies:

Starches:

Meats:

Dairy:

Biometrics: weight, height, BMI, body fat and waist measurement!