Northern Nutrition

1125 E Polston Ave, Suite A
Post Falls, ID 83854
Phone: (208) 640-4502
Fax: (208) 777-7330
Email: admin@northernnutrition.net
Web: www.northernnutrition.net

New Patient Intake - Pediatric/Adolescent

General Information

Full Name (Last, First & MI):

Date of Birth: | Gender at Birth: ☐ Male ☐ Female

Parent/Guardian (Last, First & MI):

Parent/Guardian Signature: | Today's Date:

Relationship to Patient:

Parent/Guardian Phone: | Email:

Preferred Method of Contact: ☐ Call ☐ Text ☐ Email

Address: City: State: Zip Code:

Ethnicity: ☐ Caucasian ☐ Hispanic ☐ African American

☐ Asian ☐ Other:

Mother's Name: | Father's Name:

Who is completing this intake paperwork?

Would you be open to having a student or trainee sit in on your visit(s) with us as a teaching tool for them?

☐ Yes ☐ No

Who does the patient live with? Please list family members & ages:

Is there anything we should know about that could interfere with the patient's ability to learn?

☐ None ☐ Hearing ☐ Vision ☐ Reading

☐ Language ☐ Psychological

☐ Other/Explain: _____

Education: What grade level is the patient in? _____

Employment: Does the patient have a job? ☐ YES ☐ NO

If so, what does the patient do for work? _____

What are the patient's typical work days/hours? _____

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Insurance & Billing

If we are billing insurance, please bring your insurance card(s) to your appointment.
Not all insurance companies provide coverage for Medication Nutrition Therapy (MNT) or Nutrition Counseling.
Please verify coverage with your provider. Note that patients are responsible for all non-covered charges, including co-pays, co-insurance, deductible, and/or non-covered services.

Primary Care Physician/Office:

Referring Provider:

How did you hear about Northern Nutrition? ☐ Healthcare Provider ☐ Insurance Website ☐ Friend/Family ☐ Other:

Are you open to having a student or trainee sit in on your visit(s) with us as a teaching tool?
☐ YES ☐ NO

Primary Insurance Company: _____

Subscriber ID: _____ Group #: _____

Secondary Insurance Company: _____

Subscriber ID: Group #:

Primary Reason for Visit:

(Please also list any specific goals the family, parents, and/or patient have).

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Medical History

	Self	Relative		Self	Relative
Autism Spectrum Disorder	☐	☐	Osteoporosis	☐	☐
Anxiety	☐	☐	Prediabetes	☐	☐
Depression	☐	☐	Type 2 Diabetes	☐	☐
Irritable Bowel Syndrome	☐	☐	Type 1 Diabetes	☐	☐
Constipation	☐	☐	High Blood Pressure	☐	☐
Diarrhea	☐	☐	High Cholesterol	☐	☐
Heartburn	☐	☐	Cancer	☐	☐
Bowel Resection	☐	☐	Failure to Thrive	☐	☐
Swallowing/Chewing Difficulty	☐	☐	Other/Explain:		
Diagnosed Eating Disorder	☐	☐			
Celiac Disease	☐	☐			

Medications/Supplements

Medication/Supplement	Dose	Reason for Taking	Start Date
Ex. Multivitamin	1 tablet daily	General Health	3/1/2024

If the patient takes more medications than there is space for, please bring a list to your appointment.

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Nutrition Assessment

Height (feet, inches):	Current Weight (lbs):	Desired Weight:

In the past month, has the patient: ☐ Lost Weight ☐ Gained Weight ☐ No Change

If the patient lost weight, was it: ☐ Intentional ☐ Unintentional

Does the patient have any dietary restrictions? (include food allergies/intolerances)

Does the patient use a feeding tube? ☐ Yes ☐ No

If so, please answer the questions below:

Type of Tube	Dates	Formula Name	Amount
Nasogastric (NG-tube)			
Gastrostomy (G-tube)			
Jejunostomy (J-tube)			
Other:			

Frequency of bowel movements: _____ times ☐ per Day ☐ per Month

Consistency of bowel movements: ☐ Hard ☐ Soft ☐ Loose ☐ Watery ☐ Floating ☐ Pellets

On average, how much water does the patient drink per day? _____

Does the patient have a pacemaker in place? ☐ Yes ☐ No

How often does the patient go out to eat/get take-out? And where?

_____

Does the patient skip meals? ☐ No ☐ Sometimes

If so, how often? _____ x/wk

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Nutrition Assessment continued...

Give a sample of your typical eating routine:

Time: _____ Breakfast: _____

Time: _____ Snack: _____

Time: _____ Lunch: _____

Time: _____ Snack: _____

Time: _____ Dinner: _____

Time: _____ Snack: _____

How often do you eat the following foods?	Daily/often	Occasionally	Never	Rarely
Fruit (ex. Apples, Bananas, Berries, etc.)	☐	☐	☐	☐
Vegetables (Potatoes, Broccoli, Salad, etc.)	☐	☐	☐	☐
Meat (Ex. Chicken, Fish, Steak, etc.)	☐	☐	☐	☐
Dairy (ex. Milk, Cheese, Yogurt, etc.)	☐	☐	☐	☐
Grains (ex. Bread, Rice, Oats, etc.)	☐	☐	☐	☐
Sugary Beverages (ex. Juice, Soda Pop, etc.)	☐	☐	☐	☐

Lifestyle Assessment

Does the patient have P.E./Gym class at school?
☐ Yes ☐ No

If so, how many days/wk? _____ x/wk

Do you get activity/play sports on a regular basis?
☐ Yes ☐ No

If so, how often? _____ x/wk

How much activity does the patient get? ☐ 1-30 min/day ☐ 30-60 min ☐ 60+ min

What type of activity/sport do you do/play? _____

Does the patient have any physical limitations to exercise? ☐ Yes ☐ No

If so, please explain what limits the patient's physical activity? _____