

BETTER FOOD CHOICES CONSULTATION FORM
[Please print, complete, and fax to: 561.361.3124]

Parent's Name _____

Address _____

Email Address _____

Child's Name _____ Age _____

Blood type _____ Height _____ Weight _____

Allergies _____

Child's Interests (Fill in only those that apply.)

Academics _____

Athletics _____

Artistic _____

Number of children in family Boy ____ Age ____ Girl ____ Age ____

Favorite Breakfast Food and Drinks _____

Favorite Lunch Food and Drinks _____

Favorite Snack Food and Drinks _____

Favorite Dinner Food and Drinks _____

Favorite Color _____ Does he/she like eggs? _____

What vegetables, fruit, grains, nuts/seeds legumes (beans), fish, meat does he/she like? _____

What vegetables, fruit, grains, nuts, seeds, legumes (beans), fish, meat does he/she refuse to eat? _____

What beverage does he/she drink the most? _____

Please fill out this chart listing what you son/daughter ate and drank last week.

MONDAY

Breakfast _____

Lunch _____

Snack _____

Dinner _____

TUESDAY

Breakfast _____

Lunch _____

Snack _____

Dinner _____

WEDNESDAY

Breakfast _____

Lunch _____

Snack _____

Dinner _____

THURSDAY

Breakfast _____

Lunch _____

Snack _____

Dinner _____

FRIDAY

Breakfast _____

Lunch _____

Snack _____

Dinner _____

SATURDAY

Breakfast _____

Lunch _____

Snack _____

Dinner _____

SUNDAY

Breakfast _____

Lunch _____

Snack _____

Dinner _____

What is your number-one challenge when feeding him/her? _____

What is your number-one health/concern for your son/daughter? _____

The question and answers offered in this consultation will be held strictly confidential. They are not intended to serve as replacements for professional medical advice. The authors disclaim any and all liability arising directly or indirectly from the use or application of any of the consultation information. A health care professional should be consulted regarding your specific situation.

(Please feel free to add your own comments.)