Pediatric Nutrition a division of

Achieve Nutrition Results Program (ANRP) / GIBNC

Nancy Lum RD, LDN & Annie Deremeik RD, LDN

Welcome to Achieve Nutrition Results Program (ANRP), a division of The GI and Bariatric Nutrition Center. Nancy Lum, RD, LDN, President/ Owner, has been practicing since 2001 and has been involved in multiple medical disciplines with a concentration in GI and Bariatric Nutrition since 2002. She created the Bariatric Nutrition program at Sinai Hospital in Baltimore, MD in 2003 and has been published in The Bariatric times in 2010 and 2011. In addition to running the Bariatric Program for St. Agnes Hospital, Nancy also provides nutrition guidance for multiple GI diagnoses, diabetes, cardiac, and non-surgical weight loss. Annie holds a Board Certification in Pediatric Nutrition and Certificate in Weight Management from the Commission on Dietetic Registration and specializes in pediatric nutrition. Together, Nancy and Annie operate a division of GIBNC called Achieve Nutrition Results Program "ANRP", to help clients **ACHIEVE** their health and nutrition goals through cutting edge nutrition education that creates
Awareness Change Health Independence Education Vision & Empowerment in their lives. Nancy is also co-founder of STRIVE Motivational Group Therapy – est. 2012; which focuses on nutrition, lifestyle and behavior modification to get to the root cause of eating habits. Our primary goal as nutrition experts is to build long-term relationships with patients and their families by educating, encouraging, supporting, and leading patients through the journey of permanent lifestyle change.

Annie meets with all of our pediatric patients and their families. Please remember to bring a copy of your child's growth curves with you to the appointment. You will need to request these from your child's pediatrician. For children under the age of 15, Annie meets with each child's parent(s) or caretaker(s) alone during the first appointment. At that appointment, Annie and the parent(s)/caretaker(s) will discuss when it is appropriate for the child to accompany the parent(s)/caregiver(s) to visits. In some cases, when agreed upon by parent(s)/caregiver(s), Annie may meet with the child alone during subsequent visits.

ANRP does not participate with insurance companies, including Medicare and Medicaid. Payment is due, in full, at the time of service. We reserve the right to refuse service if payment is not made at the time of service. Please see our attached "Financial Policy" for details on fees.

Please read the attached paperwork prior to your appointment and complete the attached questionnaire and forms. By signing, you are agreeing to enter into a consultation agreement with Nancy Lum, RD, LDN or Annie Deremeik RD, LDN at ANRP and understand your financial responsibilities to ANRP/GIBNC.

Sincerely,

Nancy Lum

Nancy Lum, RD, LDN, President/Owner

P: 443-490-1240 / F: 443-490-5060
Websites & Social Media:
ANRP www.ANRPtoday.com, GIBNC www.Nutrition5.com; STRIVE MD Motivational Series, www.StriveMD.com
Facebook: https://www.Facebook.com/GIBNC
Twitter: https://Twitter.com/#!/GIBNC
Pinterest: https://Pinterest.com/GIBNC
YouTube: http://www.Youtube.com/user/GIBNC5

Annie Deremeik RD, LDN

New Patient Pediatric Nutrition Assessment:

It is REQUIRED that you bring this questionnaire **completed** to your appointment.

Please complete questionnaire and attached forms below. Bring completed forms as well as a copy of your child's growth curves to your initial consultation, as they are a required part of the documentation needed. Failure to bring this completed to your consultation will result in us not being able to properly assess your child. We do not accept personal checks. Acceptable methods of payment are: Visa, MasterCard, American Express, money order, cash or cashier's checks.

There is a $5.00 fee for printing this questionnaire at appointment *if you fail to bring with you.*

You may also opt to email this to us as an attachment via our contact form on www.ANRPtoday.com or fax to 443-490-5060.

PATIENT CONTACT INFORMATION

Today's Date: _____/_____/_____

FIRST NAME, MIDDLE INITIAL	LAST NAME	DOB ____/____/____ MM DD YYYY	AGE

Parent(s)/Caretaker(s) Names: Relationship to patient:	**MEDICAL INSURANCE PROVIDER:** **Is this Medicare, Medicaid, or Medical Assistance?** ☐ YES ☐ NO

Do we have permission to release your information to your family & referring physician(s), when appropriate, in order to better coordinate your care? ☐ **YES** ☐ **NO** **If YES, Please complete the attached form on pages 12-13**

STREET ADDRESS (include unit number)	CITY, STATE	ZIP

HOME PHONE	MOBILE PHONE	WORK PHONE

EMAIL ADDRESS	Would you like to be added to our EMAIL support group list? ☐ YES ☐ NO

PARENT/CARETAKER OCCUPATION	HOURS WORKED WEEKLY _____ HRS a week	DO YOU TRAVEL FOR WORK? ☐ YES ☐ NO How often? _____

Who does your child live with?	What grade is your child in at school?

Goals and Readiness Assessment:

I would like to meet with the dietitian, today because:

_____

_____

_____

My food and nutrition-related goals for my child are:

_____

_____

_____

My overall, health goals for my child are:

_____

_____

_____

If I could change 3 things about my child's health and nutritional habits, they would be:

1. _____
2. _____
3. _____

MY CHILD'S PHYSICAL ACTIVITY HABITS

What Type of Activities does your child participate in? (circle all that apply):

Soccer	Swimming	Baseball/Softball	Dance	Band
Football	Basketball	Golf	Marital Arts	Cross Country/Running
Tennis	Lacrosse	Track	Volleyball	Other:

Physical Activity: Using the table please describe your physical activity:			
Activity	**Type/Intensity (low-moderate-high)**	**# Days per week**	**Duration (minutes)**
Stretching/Yoga			
Cardio/Aerobics (walking, jogging, biking, dancing etc.)			
Strength-training (weight lifting, Pilates, TRX, some yoga)			
Other (specify/describe)			

ACTIVITY SCHEDULE

	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
TIME OF DAY / DURATION							
TIME OF DAY / DURATION							

PHYSICAL INFORMATION

What was your child's last measured WEIGHT?	_____#
What was your child's last measured HEIGHT	_____' _____"
Has your child's growth and Development been normal?	YES NO
Has your child had any recent changes in weight that you are concerned about? If YES, please explain:	YES NO
In the last 6 months has your child (check one, then enter amount to right) ☐ **GAINED** ☐ **LOST**	_____#

FAMILY MEDICAL HISTORY

COMORBIDITIES	☑	DIGESTIVE/ GI RELATED DISORDERS	☑	OTHER CONDITIONS	☑
CORONARY ARTERY DISEASE		BARRETTS ESOPHAGUS		ANEMIA/ IRON DEFICIENCY	
DIABETES TYPE I		CELIAC DISEASE		ANXIETY	
DIABETESE TYPE II		CHRONIC CONSTIPATION		BIPOLAR	
HIGH BLOOD PRESSURE (aka Hypertension or HTN)		CROHNS DISEASE		DEPRESSION	
HIGH CHOLESTEROL		DIVERTICULITIS		GRAVES DISEASE	
PRE-DIABETES		DIVERTICULOSIS		HASHIMOTOS DISEASE	
SLEEP APNEA		IRRITABLE BOWEL (IBS/ IBD)		HYPERTHYROIDISM	
HIGH TRIGLYCERIDES		REFLUX DISEASE (GERD)		HYPOTHYROIDISM	
		ULCERATIVE COLITIS		LACTOSE INTOLERANT	
				OCD	
				OSTEOPENIA	
				OSTEOPOROSIS	
				PCOS	
				PSORIATIC ARTHRITIS	
				RHEUMATOID ARTHRITIS	
				STROKE	
				VITAMIN D DEFICIENCY	

Your Child's Current Medical Symptoms:					
HEAD	☑	**EYES**	☑	**SKIN**	☑
Headaches		Bags or Dark Circles		Acne	
Faintness		Blurred or tunnel vision (does not include near/far-sightedness		Hives, rashes, dry skin	
Dizziness				Hair loss	
Insomnia				Flushing, hot flashes	
				Excessive sweating	
HEART	☑	**DIGESTIVE TRACT**	☑	**JOINT/MUSCLE**	☑
Irregular or skipped heartbeat		Nausea, vomiting		Pain or aches in joints	
Rapid or pounding heartbeat		Diarrhea		Arthritis	
Chest pain		Constipation		Stiffness or limitation of movement	
		Bloated feeling		Pain or aches in muscles	
		Belching, passing gas		Feeling of weakness or tiredness	
		Heartburn			
		Intestinal/stomach pain			
WEIGHT	☑	**ENERGY/ACTIVITY**	☑	**MIND**	☑
Binge eating/drinking		Fatigue, sluggishness		Poor memory	
Craving certain foods		Apathy, lethargy		Confusion, poor comprehension	
Excessive weight		Hyperactivity		Poor physical coordination	
Compulsive eating		Restlessness		Difficulty in making decisions	
Water retention					
Underweight					
EMOTIONS	☑	**MENSTURATION**	☑	**OTHER**	☑
Mood swings		Menstrual cycle		Frequent illness	
Anxiety, fear, nervousness		Irregular cycles		Frequent or urgent urination	
Anger, irritability, aggressiveness					
Depression					

Has your daughter started her menstrual cycle? YES NO N/A
If answered yes, date of 1st menstrual period _____

What was your child's birth weight? ____ lbs ____oz Full Term? YES NO If No, how early?
Were their any problems during pregnancy, labor or delivery?
Was your child breast fed as a newborn? YES NO

PLEASE LIST ANY OTHER CURRENT OR PAST MEDICAL CONDITIONS

HAS YOUR CHILD EVERY BEEN HOSPITALIZED OVERNIGHT? YES NO
PREVIOUS SURGICAL PROCEDURES:

PROCEDURE	DATE

FOOD ALLERGIES AND INTOLERANCES/EATING HABITS HISTORY (please answer for your child)

FOOD ALLERGIES (PLEASE LIST) (ex. Shellfish, strawberries, nuts, eggs, soy, etc.):

REACTION (check all that apply):

☐ **HIVES** ☐ **SWELLING OF TONGUE** ☐ **TROUBLE BREATHING**

FOOD INTOLERANCES (check all that apply):

☐ **LACTOSE (milk/ dairy)** ☐ **SPICEY** ☐ **ACIDIC** ☐ **CAFFEINE**

☐ **SUGAR SUBSTITUTES** ☐ **MSG** ☐ **GLUTEN**

OTHER:

Does your child follow any special diet or have diet restrictions or limitations for any reason (health, cultural, religious, or other)?

YES NO

If YES, please describe:

Please check anything you look for on food labels when shopping for your child/family:

☐ Low Fat ☐ Low Carb ☐ Lacto Ovo Vegetarian ☐ No Wheat ☐ Weight gain ☐ High Fiber/ Whole Grains

☐ No Gluten ☐ Vegetarian ☐ Pescetarian ☐ High Protein ☐ Low Sodium ☐ Other

☐ No Dairy ☐ Vegan ☐ Weight loss ☐ Diabetic ☐ Low Sugar

Which meals does your child eat regularly, check all that apply:

☐ Breakfast ☐ Lunch ☐ Dinner ☐ Snacks (time _____)

The nutrition/eating habits that are most challenging for my child:

My child's nutrition/eating habits that I am most pleased with are:

DIGESTIVE HISTORY

How often does your child have a bowel movement?

Do he/she take laxatives or stool softeners? YES NO

If yes, please list type/brand and how often:

Please describe your child's typical bowel movements (circle one): Hard Soft Loose

Please indicate how often your child experiences the following symptoms (circle one):

Heartburn	Often	Sometimes	Rarely	Never
Gas	Often	Sometimes	Rarely	Never
Bloating	Often	Sometimes	Rarely	Never
Stomach Pain	Often	Sometimes	Rarely	Never
Nausea/ Vomiting	Often	Sometimes	Rarely	Never
Diarrhea	Often	Sometimes	Rarely	Never
Constipation	Often	Sometimes	Rarely	Never

Does your child have any history of eating disorders? (Ex. Binge eating and then vomiting, Binge eating compulsively large quantities of food without vomiting, Waking up and eating late at night, or not eating or eating very little for long periods of time)?

☐ YES ☐ NO

If yes,

Type of disorder:

Age when disorder first occurred/ year:

Duration:

IF YES, WE MAY REFER YOU TO ANOTHER PROVIDER WHO SPECIALIZES IN TREATMENT OF EATING DISORDERS

PLEASE LIST YOUR CHILD'S CURRENT MEDICATIONS	
MEDICATION	**DOSAGE**

Current Vitamins/ Minerals	Brand	Dosage	Dietary Supplements	☑
Multivitamin			Fiber	
Calcium			DHA	
Vitamin A			OMEGA 3/6/9	
Vitamin B6			Fish Oil	
Vitamin B12			Flaxseed Oil	
Vitamin C			DHEA	
Vitamin D			Glucosamine	
Vitamin E			Chondroitin	
Iron			Black Kohash	
			Premerin	
OTHER:			OTHER:	

SPECIAL NEEDS

Do you or your child have any special needs for education materials, or grocery shopping due to (check all that apply):

☐ YES ☐ NO

☐ Low literacy ☐ Poor eyesight ☐ Poor hearing ☐ Does not speak English

☐ Unable to stand/walk/drive vehicle ☐ Unable to cook food due to inability to stand for any length of time

☐ Unable to grocery shop due to inability to drive or stand

If **YES**,

Is there a support person assisting the patient with:

☐ Traveling to appointments ☐ Language Interpretation ☐ Reading food/recipe labels and education materials

☐ Cooking ☐ Grocery Shopping

Fluids & Foods

Beverage Type	Daily Amount	Weekly Amount	If sweetened please list sweetener used:	Serving Size (Ex. 1 cup, 8 ounces, 1 sandwich, etc.)
Coffee (☐ reg ☐ decaf ☐ latte)				
Water				
Tea (☐ reg ☐ decaf)				
Sports/ Performance drinks, TYPE: _____				
Juice (☐ natural ☐ fruit drinks)				
Soda (☐ reg ☐ diet)				
Milk (☐ whole ☐ 2% ☐ 1% ☐ skim)				
Milk Alternative/FORMULA/Breast Milk TYPE: _____				
OTHER:				

How often does your child eat:	Never	2-3 times/month	1 time/week	2-3 times/week	1 time/day	2-3 times/day
Fast food						
Restaurant food						
Vending machine food						
School Cafeteria food						
Visit buffets						
Frozen meals						
Home-prepared meals						
Beef						
Poultry						
Pork						
Fish/Seafood						
Lamb						
Deli Meat						
Beans/Legumes						
Green Salads						
Fresh, raw Vegetables						
Fresh/ frozen, fruits						
Canned/packaged vegetables or fruit						
Cooked vegetables						
French fries						
Fried foods						
Crackers, chips, pretzels						
Sweets (cookies, cakes, muffins, pies)						
Whole grains						
Dairy (milk, yogurt, cheese, butter)						

Please check ALL food your child eats on a regular basis; if not listed, please fill in the blanks:

Dairy	Vegetables	Fruit	Protein	Grains
☐ Almond Milk	☐ Artichokes	☐ Apple	☐ Bacon	☐ Cereals
☐ Cashew Milk	☐ Asparagus	☐ Apricots	☐ Beef	☐ Chia Seeds
☐ Coconut Milk	☐ Avocado	☐ Banana	☐ Bison	☐ Corn Tortillas
☐ Cottage Cheese	☐ Beans	☐ Blackberries	☐ Chicken	☐ Couscous
☐ Cow Milk	☐ Broccoli	☐ Blueberries	☐ Egg Beaters	☐ Crackers
☐ Hard Cheese (Parmesan)	☐ Brussel Sprouts	☐ Cantaloupe	☐ Egg whites	☐ Crackers
☐ Ice Cream	☐ Cabbage	☐ Cherries	☐ Eggs – whole	☐ Deli Flats
☐ Kefir	☐ Carrots	☐ Clementine	☐ Fish	☐ English Muffin
☐ Pudding	☐ Cauliflower	☐ Cranberries	☐ Ham	☐ Flax Seeds
☐ Rice Milk	☐ Celery	☐ Dried Fruit	☐ Kidney, Pinto, Black, Navy, White, Soy, Lima Beans	☐ Flour Tortillas
☐ Soft Cheese (Ricotta)	☐ Corn	☐ Grapefruit	☐ Lentils	☐ Grits
☐ Sour Cream	☐ Cucumber	☐ Grapes	☐ Nuts	☐ Oatmeal
☐ Soy Milk	☐ Eggplant	☐ Honeydew	☐ Peas, Split Peas Chickpeas, Black-Eye Pease	☐ Pasta
☐ Yogurt	☐ Kale	☐ Juice	☐ Pork	☐ Pita
☐	☐ Lettuce	☐ Kiwi	☐ Seafood	☐ Popcorn
☐	☐ Mushrooms	☐ Mango	☐ Seeds	☐ Pretzels
☐	☐ Okra	☐ Orange	☐ Tofu	☐ Quinoa
☐	☐ Onion	☐ Papaya	☐ Turkey	☐ Rice
☐	☐ Peppers	☐ Pears	☐	☐ Wheat Tortillas
☐	☐ Potatoes	☐ Pineapple	☐	☐ White Bread/Rolls
☐	☐ Pumpkin	☐ Plums	☐	☐ Whole Grain Bread/Rolls
☐	☐ Spinach	☐ Raspberries	☐	☐
☐	☐ Squash	☐ Strawberries	☐	☐
☐	☐ Tomatoes	☐ Tangerine	☐	☐
☐	☐ Zucchini	☐ Watermelon	☐	☐
☐	☐	☐	☐	☐
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24 HOUR FOOD RECALL

PLEASE LIST ANY FOOD AND/OR DRINK YOUR CHILD HAS CONSUMED IN THE LAST 24 HOURS.

Meal/ Snack	Time Eaten	Place (ex. home, cafeteria, name of restaurant)	Description of food item(s) / Meal	Serving Size (Ex. 1 cup, 8 ounces, 1 sandwich, etc.)
Breakfast				
Snack				
Lunch				
Snack				
Dinner				
Snack				

Who prepares your child's meals at home?

Who does the majority of your child's grocery shopping?

Are meals cooked at home low fat? (CHECK ONE) ☐ All the time ☐ Sometimes ☐ Never

What kinds of fats do you use at home for frying and sautéing?
□ Butter □ Margarine □ Olive Oil □ PAM Spray □ Canola Oil □ Peanut Oil
□ Walnut Oil □ Avocado Oil □ Sesame Oil □ Shortening □ Lard
Other:

What kinds of spreads do you use on breads, vegetables, etc.?
□ Butter □ Margarine □ Olive Oil □ Reduced Calorie Margarine □ Olive oil butter

Do you ever use sugar substitutes? □ YES □ NO, If YES,
□ Splenda □ Stevia □ Truvia □ Monk Fruit □ Sweet-N-Low □ Equal
Other:

What are the food(s)/ drink(s) that your child would you have the hardest time giving up?

Do your child ever wake up in the middle of the night hungry? □ YES □ NO
If YES, how often?

On average, how many hours of sleep does your child get per night?

Does your child ever binge on food until he or she is uncomfortable or ill? □ YES □ NO
If YES, how often?

What foods does your child ask for most often?

_____

_____

_____

Please List your Child's Food dislikes:

_____

_____

Eating Style: based on how you eat on a regular basis, please check all that apply

□ Fast eater	□ Erratic eater	□ Emotional eater (stressed, bored, sad, etc.)	□ Late-night eater
□ Time constraints	□ Dislike "healthy" food	□ Travel frequently	□ Do not plan meals/menu
□ Rely on convenience items	□ Family member(s) have different tastes	□ Love to eat	□ Eat too much
□ Eat to a point of feeling uncomfortable	□ Eat because I have to	□ Negative relationship with food	□ Struggle with eating issues
□ Confused about food/nutrition	□ "Grab and go" foods	□ Frequently eat out	□ Poor snack choices

My signature confirms that all of the above information is accurate. I further understand that it is my responsibility to report any changes in my contact information to Annie Deremeik RD, LDN by calling our office on 443-490-1240.

Please bring this questionnaire with you along with your child's growth curves from the pediatrician's office to your initial consultation; there is a $5.00 fee for printing this questionnaire for you. You may also opt to fax to 443-490-5060 or scan and email through our website at www.ANRPtoday.com prior to your appointment.

X _____ _____

Signature of Patient (if over 18 years) Date

X _____ _____

Signature of Guardian Date

Materials developed for The GI and Bariatric Nutrition Center, LLC for Nancy Lum, RD, LDN