Welcome to testing

Dear Patient or Parent:

You/your child will be undergoing testing for histamine sensitivity. In order to receive the most benefit from testing, your help and cooperation is essential. **Please do not wear cologne or anything with any scent including tobacco smoke or fabric softeners. You will be unable to enter the testing room if you have any fragrances on.** You will be required to take self or child’s pulse during the testing process. You will be asked to observe behavioral changes, changes in appearance, and any other symptoms patient may be experiencing. You will be given a timer to be set after each dose you/your child receives. Testing is done by intradermal injections. The timer will beep at five minute at which time you will need to take you/your child’s pulse for 15 seconds and record it on the symptoms sheet then you or your child must self sign his/her name. If your patient is too young to be able to write his/her name, you may have your child draw a picture. Have appropriate concentration work ready. Restart the timer for 5 minutes for concentration work. When the timer beeps after the five minutes have expired note any symptoms you observed or your child felt thought out the 10 mins. Next please send your child or self with his/her chart to the tester for evaluation and possible next injection. Your keeping accurate notes during the testing process will enable the tester to obtain the best results possible.

Our goal is to discover how these allergies affect you or your child’s ability to function. They will do skin testing for histamine and blood testing for individual foods and inhalants. We want the most for the patient. For some patients identifying theses sensitivities and treating them enables the patient to concentrate more easily, ease some of their frustrations, and yours, and help life to be more enjoyable.

If you have any questions or concerns during this process, please feel at ease to discuss them with the tester and/or Dr. Block. We look forward to having you and your child work with us to help make your testing experience a rewarding one.

**Patients with asthma, please bring your rescue inhaler (albuterol, proventil) and peak flow meter if you have one.**

**YOU MUST SEE THAT THE PATIENT TAKES NO MULTI-VITAMINS, ANTIHISTAMINES, HERBS, OR HOMEOPATHIC DRUGS FOR ALLERGIES FOR ONE WEEK. NO STEROIDS/INHALERS FOR 30 DAYS. AND NO VITAMIN C FOR 72 HOURS PRIOR TO THE TESTING APPOINTMENT.** You will be here for several hours so come dressed in a short sleeve shirt with a light jacket. Room temperature stays at 70 degrees. **Please wear something with short sleeves.** The testing will be done on their upper arm. The tester will be glad to teach you to take your child’s pulse. **Please bring some school work or age appropriate concentration work for you/child to work on during testing so you can evaluate changes in his/her concentration. Please bring a mid morning and/or mid afternoon protein snack (nuts, eggs, meat, cheese) and water.** We look forward to seeing you and your child in your testing department.

You will be here from 8:30am to 11:30am and then from 1:30pm to 3:00pm. Thank you.

___________________________________________
Signature

___________________________________________
Date
Please read and complete the following paperwork prior to your appointment at The Block Center.

Please select the appropriate history form as well. The child’s form is for age birth to 18 years of age. The adult form is for over 18 years old.

The Block Center
PROVIDER NOTICE
OF INFORMATION PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Uses and disclosures of health information

We seek your consent to use health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive. You can revoke your consent.

We may use or disclose identifiable health information about you without your authorization for several reasons. Subject to certain requirements, we may give out health information without your authorization for public health purposes, for auditing purposes, for research studies, and for emergencies. We provide information when otherwise required by law, such as for law enforcement in specific circumstances. In any other situation, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures.

We may change our policies at any time. Before we make a significant change in our policies, we will change our notice and post the new notice in the waiting area and in each examination room. You can also request a copy of our notice at any time. For more information about our privacy practices, contact The Block Center.

Individual rights

In most cases, you have the right to look at or get a copy of health information about you that we use to make decisions about you. If you request copies, we will charge you $25.00 (twenty five dollars) for the first twenty pages, $0.50 (50 cents) for each page thereafter, and $9.40 to mail certified with return receipt. You also have the right to receive a list of instances where we have disclosed health information about you for reasons other than treatment, payment or related administrative purposes. If you believe that information in your record is incorrect or if important information is missing, you have the right to request that we correct the existing information or add the missing information.

Complaints

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact The Block Center. You also may send a written complaint to the U.S. Department of Health and Human Services. The person listed below can provide you with the appropriate address upon request.

Our legal duty

We are required by law to protect the privacy of your information, provide this notice about our information practices, and follow the information practices that are described in this notice.

If you have any questions or complaints, please contact:

The Block Center
1750 Norwood Drive
Hurst, Texas 76054
Phone: (817) 280-9933

I hereby declare that I have received and read the copy of The Block Center’s Provider Notice of Information Practices.

Patient’s printed name _____________________________________________

Signature of patient or parent (if minor child) __________________________

Date __________________________
IT IS IMPORTANT THAT YOU OR ANYONE COMING WITH YOU NOT WEAR ANY PERFUME, COLOGNE, AFTERSHAVE OR FRAGRANCES OF ANY KIND TO THE OFFICE. THIS ALSO INCLUDES TOBACCO ODORS, SHAMPOO, HAIR SPRAY AND FABRIC SOFTENER WITH FRAGRANCE. DUE TO THE SENSITIVITIES OF DR. BLOCK AND OTHERS IN OFFICE, YOU WILL BE UNABLE TO ENTER THE OFFICE IF YOU ARE WEARING ANY FRAGRANCE. IF YOU DO COME TO THE OFFICE WITH ANY FRAGRANCE ON, ARRIVE MORE THAN 15 MINUTES LATE OR DO NOT HAVE YOUR PAPERWORK FILLED OUT COMPLETELY, YOU WILL BE REQUIRED TO RESCHEDULE YOUR APPOINTMENT AND FORFEIT YOUR DEPOSIT.

Payment is due at the time service are rendered and is payable by cash, check, MasterCard, or Visa.

We require 24 hours notice for rescheduling appointments. If you have any questions about your appointment please call during office hours so that we may clarify them prior to your visit.

We look forward to your visit.

I understand that The Block Center does not accept insurance for payment and that I am responsible for payment of all of my medical care. I understand that payment is due at the time of service.

If you will be filing claims with your insurance company you will need to sign an authorization to release information. Many times your insurance company will request more information from our office before they will process your claim. Please fill out the attached authorization with your insurance information. Without this signed consent we will be unable to release the information and your claim will not be processed. If your insurance company requests copies of your medical records, you will be billed for the cost of making the copies and mailing them to the insurance company. The charge approved by the State of Texas for this service is $25.00 for the first 20 pages and $0.50 for each page thereafter. There will also be fees for mailing the records. These fees include a certified fee, a returned receipt fee and the postage fee. These fees vary in price depending upon how much the copies weigh and the location or ‘zone’ they are being mailed to. We mail all medical records certified, return receipt so that we have proof that your insurance company did in fact receive your records.

Please initial below:

_____ I agree to have the Block Center mail copies of my medical records to my insurance company and I agree to pay the fees as outlined above each time my insurance company requests copies of my medical records.

_____ I do not want The Block Center to send copies of my medical records to my insurance company.

________________________________________________
Signature of Patient or Responsible Party

________________________________________________
Date
PATIENT RECORD OF DISCLOSURE

In general the HIPPA privacy rule gives patients the right to request on uses and disclosures of their protected health information (PHI). The patient is also provided the right to request confidential communications or that a communication of PHI is made by alternative means, such as sending correspondence to the individual’s office instead of the individual’s home. This information will remain in effect until revoked in writing.

I wish to be contacted in the following manner (check all that apply):

- Home/Cell Telephone
- O.K. to leave message with detailed information
- Leave name/doctor with call back number only
- Work number
- Leave detailed message on work voice mail
- Leave name/doctor with call back number only
- When unable to contact me by phone, a written communication may be sent to my home address
- Other

___________________________________________
Print name of patient

___________________
Birth Date

Signature of patient or guardian

Date

Healthcare providers must keep records of PHI disclosures.

Medicaid Release Information

I, ______________________________________, (Patient or parent/guardian of patient) understand that Dr. Mary Ann Block is not a Medicaid provider. I understand that my relationship with The Block Center is based on private pay and that I am responsible for all fees related to medical care. I understand that these fees are due at the time of service. I understand that no Medicaid claims will be or can be filed on my behalf for any services at The Block Center.

___________________________________________
(Signature of patient or parent/guardian of patient)
Dear Family:

You or your child will be undergoing various tests for either foods, inhalants or histamine sensitivities. In order to receive the most benefit from testing, your help and cooperation is essential. **Please do not wear cologne or anything with any scent including tobacco smoke or fabric softeners. You will be unable to enter the testing room if you have any fragrances on.**

You will be required to take your child’s or your pulse during the testing process. You will be asked to observed behavioral changes, changes in appearance, and any other symptoms you or your child may be experiencing. You will be given a timer to be set after each dose you or your child receives. Testing is done by intradermal injections. The timer will beep at five minute at which time you will need to take you or your child’s pulse for 15 seconds and record it on the symptoms sheet then have your child sign his/her name or you will sign your name. If your child is too young to be able to write his/her name, you may have your child draw a picture. Have appropriate concentration work ready. Restart the timer for 5 minutes for concentration work. When the timer beeps after the five minutes have expired note any symptoms you observed or you or your child felt thought out the 10 minutes. Next please see the tester with your or your child’s chart for evaluation and possible next injection. Your keeping accurate notes during the testing process will enable the tester to obtain the best results possible.

Our goal is to discover what sensitivities your child has and how these sensitivities affect your child’s ability to function. We want the most for your child and you. For some children identifying these sensitivities and treating them enables the child to concentrate more easily, ease some of their frustrations, and yours, and help life to be more enjoyable.

If you have any questions or concerns during this process, please feel at ease to discuss them with the tester and/or Dr. Block.

We look forward to having you and your child work with us to help make your testing experience a rewarding one.

**YOU MUST SEE THAT YOU OR YOUR CHILD TAKE NO ANTIHISTAMINES OR HERBS, HOMEOPATHIC DRUGS FOR ALLERGIES FOR ONE WEEK OR VITAMIN C FOR 72 HOURS PRIOR TO THE TESTING APPOINTMENT.** You will be here for several hours so come dressed in warm comfortable clothes. Room temperature stays at 70 degrees. Please write down all the foods you or your child has eaten that day. Make sure you or your child have eaten 4 or 5 of the foods that you eat on a regular basis. We will either be testing these foods or histamine, so if you have certain foods you want tested, please be sure to speak to the tester about this. You or your child will need to wear something with short sleeves. The testing will be done on their upper arm. The tester will be glad to teach you to take your or your child’s pulse. Please bring some school work or age appropriate concentration work for you or your child to work on during testing so you can evaluate changes in concentration. Please bring a mid morning and/or mid afternoon protein snack (nuts, eggs, meat, cheese). We look forward to seeing you and your child in your testing department.

You will be here from 8:30am to 11:30am and then from 1:30pm to 4:00pm. Thank you.

___________________________________________  ___________________
Signature                                    Date

______________________________________________
Name of Patient

______________________________________________
Name of Parent or Guardian
New Patient Personal Information Sheet

**Personal Information:**

<table>
<thead>
<tr>
<th>Patient’s Full Legal Name</th>
<th>Sex</th>
<th>Birth Date</th>
<th>Race</th>
<th>Age</th>
<th>Marital Status</th>
</tr>
</thead>
<tbody>
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</table>

<table>
<thead>
<tr>
<th>Patient’s Social Security No.</th>
<th>Patient’s Driver’s License No.</th>
<th>Spouse’s Name</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Patient’s Permanent Street Address</th>
<th>City/State</th>
<th>Zip Code</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Home Phone No.</th>
<th>Cell Phone No.</th>
<th>E-Mail Address</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

I give permission for The Block Center to send me information and updates. I understand that if I receive emails from The Block Center that I cannot contact The Block Center through this email address. It is for information sent to me only.

Signature ____________________________ Date ____________

**Financial Information:**

<table>
<thead>
<tr>
<th>Responsible Party Name (First)</th>
<th>(Middle)</th>
<th>(Last)</th>
<th>Telephone No./Ext</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Social Security No.</th>
<th>Work No.</th>
<th>Driver’s License No.</th>
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</thead>
<tbody>
<tr>
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</tbody>
</table>

Please check the payment method you will be paying for your services:

( ) Cash      ( ) Check      ( ) Visa      ( ) Master Card

Credit card number for **phone appointments** or **supplement orders**

Exp date ____________ Security Code _________

IN CASE OF EMERGENCY, NOTIFY:

<table>
<thead>
<tr>
<th>Name</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
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</table>

Email address

_____________________________

(Blank)
Today’s Date_____________________

This questionnaire is to help me evaluate your child’s symptoms. This history is the single most important source of information about your child. It is estimated that 70% of health problems can be solved from the history, 20% from the physical exam and 10% from lab and X-rays. If there is a question you would rather discuss personally, without your child present, mark those with an asterisk (*).

**General Information**

Name of child_______________________________________ Date of birth_________________________

Address________________________________________ (City)_________________ (State)________ (Zip)___________

Phone(_____)_________________________________ Age_________________ Grade__________

Name of person completing questionnaire_______________________________ Relationship________________

1. How did you hear about The Block Center?______________________________________________

2. Name of primary care physician______________________________________________________

3. Descriptor problems which prompted you to call The Block Center:

   ____________________________________________
   ____________________________________________
   ____________________________________________
   ____________________________________________

4. Have you tried other professionals for this complaint?_________If Yes, explain__________________

   ____________________________________________

5. Has child had any treatment for this problem?_______If Yes, explain________________________

   ____________________________________________

6. What do you wish to accomplish?____________________________________________________

   ____________________________________________

7. Has child had all vaccines required?   Yes___________No___________

8. Has child had a medical check-up in last 12 months? Yes_________________No______________

9. Any current health problems? Yes___________No______________If yes, explain________________

   ____________________________________________

10. Has child had any psychological or educational testing? Yes_______No_______If Yes, explain____

   ____________________________________________

11. List all medications and supplements child is taking____________________________________

   ____________________________________________
Pregnancy and Birth History
1. Did mother have medical problems during pregnancy? Yes_______No_______
2. Was labor/delivery difficult? Yes_______No_______
3. Medications during pregnancy? Yes____No____
4. Was labor induced? Yes_____No_______
5. Was suction or forceps used? Yes____No____
6. Length of pregnancy_________________months 7. Duration of labor?______________________hours
8. C-Section? Yes____No_______ 9. Any complications during or after labor? Yes_____No____
10. Birth weight_______pounds_______ounces 11. APGAR Scores if known_____________ ____________
12. Was infant born ________Head first? ____Feet first? ________Breech?
13. Did infant require any special treatment at birth? Yes_____No______, If Yes, explain________________________

14. If child is adopted, age of adoption____________, Country adopted from ______________________________

Infancy
1. Breast fed? Yes______No______, If Yes, how long?____________ 2. Breast plus formula? Yes____No____
3. Formula only? Yes____No______ 4. Formula changes? Yes____No____
5. Normal weight gain? Yes_____No______ 6. Nursing or feeding problems? Yes_____No____
7. Age when solid food introduced___________________
8. Check problems that apply to first year of life:
   _____Asthma _____Congestion _____Skin Rashes _____Constipation
   _____Colic _____Colds _____Diarrhea _____Constipation
   _____Vomiting _____Excess Crying _____Diaper Rash _____Irritability
   _____Overactive _____Ear Infections _____Pneumonia _____Croup
   _____Hives _____Eczema _____Antibiotics _____Trouble Sleeping

Developmental-Approximate Age of the Following:
   _____Crawled _____Sat Alone _____Said Single Words _____Walked without Support
   _____Dressed Self _____Fed Self with Spoon _____Said Understandable Short Sentences

Problems That Apply After One Year of Age:
   _____Asthma _____Congestion _____Skin Rashes _____Diarrhea _____Clumsy _____Picky Eater
   _____Constipation _____Vomiting _____Colds _____Ear Infections _____Strep Throat _____Gas
   _____Pneumonia _____Aggression _____Bloating _____Loss of Language _____Sensitive to Light & Noise
   _____Headaches _____Nervous _____Hives _____Uncoordinated _____Trouble Sleeping
Has child had ____ Tonsillectomy? ____ Adenoidectomy? ____ Ear Tubes? ____ Age ______________

Has child taken prednisone or other steroids? Yes_____No_____

Does exposure to perfumes, pesticides or other chemicals bother child? Yes____No___ If Yes, what happens?

________________________________________________________________________________________

Has child taken antibiotics at any time? Yes_____No______ Does child crave sweets? Yes_____No____

**Systems Review-Check All That Child Currently Has:**

**General**
- ____ Recent weight loss or gain (Circle which)  ____ Over eats  ____ Fatigue  ____ Nightmares
- ____ Trouble Sleeping

**Eyes**
- ____ Tearing  ____ Circles Under  ____ Double Vision  ____ Burning
- ____ Crossed  ____ Squints  ____ Itching  ____ Blurred Vision
- ____ Wears Glasses  ____ Has Had Eye Surgery

**Ears**
- ____ Itching  ____ Draining  ____ Stopped Up  ____ Tubes
- ____ Pain  ____ Ringing  ____ Infections  ____ Difficulty Hearing

**Nose**
- ____ Congestion  ____ Discharge  ____ Picks Nose  ____ Sneezing
- ____ Bleeding  ____ Infections  ____ Postnasal Drip  ____ Wax

**Mouth/Throat**
- ____ Canker Sores  ____ Chapped Lips  ____ Bad Teeth  ____ Thrush
- ____ Sore Gums  ____ Coated Tongue  ____ Fever Blisters  ____ Bad Breath
- ____ Grinds Teeth  ____ Sore Throat  ____ Hoarse  ____ Mouth Breather
- ____ Clears Throat  ____ Swollen Glands  ____ Thyroid Disease  ____ Strep Throat

**Heart/Lungs**
- ____ Heart Murmur  ____ Cough  ____ Bronchitis  ____ Asthma
- ____ Wheezing  ____ Pneumonia  ____ Chest Pain  ____ Short of Breath
- ____ Heart Palpitations

**Stomach**
- ____ Nausea  ____ Constipation  ____ Diarrhea  ____ Blood in Stools
- ____ Pain  ____ Over Eats  ____ Vomiting  ____ Rectal Itching
- ____ Gas  ____ Soiling  ____ Belching  ____ Bloating
Systems Review - Check All That Child Currently Has:

Kidney/Bladder

_____ Urgency  _____ Frequent Urination  _____ Daytime Wetting  _____ Nighttime Wetting

_____ Pain/Burning with Urination  _____ History of Urinary Tract Infections

Age when Dry _______________ Daytime  _______________ Nighttime

Nerves/Musculoskeletal

_____ Headaches  _____ Seizures  _____ Dizziness  _____ Painful Joints

_____ Uncoordinated  _____ Tics  _____ Growing Pains  _____ Accident Prone

Skin

_____ Dry  _____ Oily  _____ Rashes  _____ Acne  _____ Easy Bruising

Behavior - Check All That Apply:

_____ Overactive  _____ Destructive  _____ Lies  _____ Steals  _____ Negative School Reports

_____ Unhappy  _____ Aggressive  _____ Fights  _____ Argues  _____ Talks Excessively

_____ Has Run Away  _____ Mood Swings  _____ Temper  _____ Hard to Discipline

_____ Disrupts Family  _____ Fire Setting  _____ Dislikes School  _____ Sexual Inappropriateness

_____ Short Attention  _____ Doesn’t Listen  _____ Doesn’t Like Self  _____ Learning Problems

Amount of television by child ______ hours per day; ______ hours per week

Amount of time spent on computer games ______ hours per day; ______ hours per week

List things child does well: ____________________________________________________________

________________________________________________________

List Child’s greatest problems, frustrations: __________________________________________

________________________________________________________

List all medications child has been prescribed: _______________________________________

________________________________________________________

List side effects caused by medications: _____________________________________________

________________________________________________________

Cooperation and consistency between child’s parents: ______ Excellent  ______ Good  ______ Fair  ______ Poor

How would you describe the child’s school situation? ______ Excellent  ______ Good  ______ Fair  ______ Poor
Family History

Length of current marriage ________Years Any marital problems? ____Yes ____No

Do parents agree about child’s treatment? ____Yes ____No Stepparent in home? ____Yes ____No

Anyone else live in house? ____Yes ____No Does anyone smoke? ____Yes ____No

Prior marriages-Mother? ____Yes ____No Father? ____Yes ____No

Birth father’s Height________ Weight________ Birth mother’s Height________ Weight________

Allergy

Has child had any allergy testing? ____Yes ____No, If Yes, what type? ____Skin ____Blood

Is child taking any type of allergy treatment currently? ____Yes ____No, If yes, what?

____Prescription______________________________________________________

____Over-the-counter __________________________________________________

____Allergy Injections ____Avoidance

Has child been to emergency room for allergies or asthma? ____Yes ____No How often?_________

How long has child lived in area? __________________

Environment

Do you live in ____House ____Apartment ____Other How long in this residence?_______________

Is garage attached ____Yes ____No Is there much vegetation(trees, weeds, etc.)? ____Yes ____No

Is there a lot of dust in the home? ____Yes ____No Does home have basement? ____Yes ____No

Is there mold/mildew in home? ____Yes ____No Is HVAC System? ____Gas ____Electric

Any pets? ____Yes ____No What kind?______________________________

Are child’s symptoms worse:

____Outdoors _______Indoors _______Rainy Days _______Windy Days

____Fall _______Summer _______Spring _______Winter

____At Night _______Weather Changes

Do you use? ____Strong smelling cleaning chemicals ____Floor/Furniture Wax ____Pesticides

Is home regularly treated for insects? ____Yes ____No Do you use electric blankets? ____Yes ____No

Do you live near a power generating station/high voltage tower/transmitter? ____Yes ____No

What kind of water do you drink? ____Tap ____Filtered ____Plastic Bottled ____Glass Bottled
IMMEDIATE FAMILY
Instructions: Please include all information you know related to the following areas. You may need to ask your parents for a complete history.

<table>
<thead>
<tr>
<th>Family Member</th>
<th>Father</th>
<th>Mother</th>
<th>Brother</th>
<th>Sister</th>
<th>Maternal Grandmother</th>
<th>Maternal Grandfather</th>
<th>Paternal Grandmother</th>
<th>Paternal Grandfather</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age if living</td>
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<td></td>
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<td>Age at death</td>
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<td>Cause of death</td>
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<td>Type of work</td>
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</table>

Mark an "X" for any positive answer

- Asthma
- Allergy Hives
- Eczema
- Hay fever
- Weight problem
- Smokers
- Alcohol abuse
- Mental illness
- Cancer
- Diabetes
- Hypertension
- Heart problem
- High cholesterol
- Thyroid disease
- Blood disease
- Bowel problem
- Ulcers
- Arthritis
- Migraines
- Other
**Food**

Is child a picky eater? ____Yes  ____No  
Most Meals Eaten at _____Home  ____Out

Favorite Foods:

______________________________________________________________________
______________________________________________________________________

Meal Times on a school day:

<table>
<thead>
<tr>
<th>Time</th>
<th>AM</th>
<th>AM/PM</th>
<th>PM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breakfast</td>
<td></td>
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</tr>
<tr>
<td>Morning Snack</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Lunch</td>
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<td></td>
</tr>
<tr>
<td>Snack</td>
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<td></td>
</tr>
<tr>
<td>Dinner</td>
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</tr>
<tr>
<td>Evening Snack</td>
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</table>

**Diet Diary:** List all food and drinks typically eaten by child in a normal week. Include all snacks, fast food and drinks.

**Sunday:**

<table>
<thead>
<tr>
<th>Time</th>
<th>AM</th>
<th>AM/PM</th>
<th>PM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breakfast</td>
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<tr>
<td>Afternoon Snack</td>
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<tr>
<td>Dinner</td>
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</tr>
<tr>
<td>Evening Snack</td>
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</tr>
</tbody>
</table>
Diet Diary Continued: List all food and drinks typically eaten by child in a normal week. Include all snacks, fast food and drinks.

Monday:

Breakfast:_________________________________________

Morning Snack:_________________________________

Lunch:_________________________________________

Afternoon Snack:_________________________________________

Dinner:_________________________________________

Evening Snack:_________________________________

Tuesday:

Breakfast:_________________________________________

Morning Snack:_________________________________

Lunch:_________________________________________

Afternoon Snack:_________________________________

Dinner:_________________________________________

Evening Snack:_________________________________
Diet Diary Continued: List all food and drinks typically eaten by child in a normal week. Include all snacks, fast food and drinks.

**Wednesday:**

Breakfast:_________________________________________

Morning Snack:_________________________________________

Lunch:____________________________________________

Afternoon Snack:____________________________________

Dinner:____________________________________________

Evening Snack:_____________________________________

**Thursday:**

Breakfast:_________________________________________

Morning Snack:_________________________________________

Lunch:____________________________________________

Afternoon Snack:____________________________________

Dinner:____________________________________________

Evening Snack:_____________________________________

Diet Diary Continued: List all food and drinks typically eaten by child in a normal week. Include all snacks, fast food and drinks.

Friday:

Breakfast:_________________________________________

Morning Snack:_____________________________________

Lunch:____________________________________________

Afternoon Snack:____________________________________

Dinner:____________________________________________

Evening Snack:_____________________________________

Saturday:

Breakfast:_________________________________________

Morning Snack:_____________________________________

Lunch:____________________________________________

Afternoon Snack:____________________________________

Dinner:____________________________________________

Evening Snack:_____________________________________

Mark all items:

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<th>1-2x Week</th>
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