PRACTICE TOOL

Diet History Assessment Tool for Children with Intestinal Failure

Child's age (years): _____

Nutrition Support

Is the child currently receiving parenteral nutrition? Yes ☐ No ☐

If "No", has the child received parenteral nutrition in the past month? Yes ☐ No ☐

Is the child currently receiving enteral nutrition via tube feedings? Yes ☐ No ☐

If "No", has the child received enteral nutrition via tube feedings in the past month? Yes ☐ No ☐

Gastrointestinal Function (in the past month)

What is the average number of stools per day that the child had? _____

What is the child's average daily ostomy output (mL)? _____

Has the child experienced any vomiting? Yes ☐ No ☐

If "Yes", how many days did the vomiting occur _____ and what is/was the average number of vomiting episodes per day? _____

Diet History and Patterns (in the past month)

How many times per day did the child usually sit to eat a meal? _____

How many snacks per day did the child usually eat? _____

Did the child routinely take any oral vitamin or mineral supplements? Yes ☐ No ☐

If yes, what was the brand(s) _____ and how many days where they taken _____?

Did the child take a fiber supplement? Yes ☐ No ☐

If yes, what was the brand(s) _____ and how many days where they taken _____?

Did the child avoid any food(s) because of changes in stools, ostomy output, or discomfort? Yes ☐ No ☐

If yes, what food(s) were avoided and why? _____

Of the foods that were consumed in the past month, how often were they pureed or blenderized?

a. Never or almost never
b. About ¼ of the time
b. About ½ of the time
d. About ¾ of the time
e. Almost always or always

In the past month, how often has the child consumed the following items? Select one frequency in each row.

	Rarely/ Never	2-3x/ month	1-2x/ week	3-4x/ week	5-6x/ week	Daily
Sugar Candy						
Chocolate Candy						
Baked goods (e.g., donuts, packaged muffins, PopTarts®, frosted snack cakes)						
Packaged cookies						
Ice-cream, ice milk, frozen yogurt, sherbet, and/or Popsicles						
Gum						
Dried fruit						
Sugar-sweetened cereals (brand: _____)						
Fast food and/or fried foods						
Syrups						
Honey butter						
Salad dressing (brand: _____)						
Sweeteners (brand: _____)						

In the past month, how often has the child typically consumed the following protein sources? Select one frequency in each row.

	Rarely/ Never	1-2x/ week	3-4x/ week	5-6x/ week	1x/ day	≥2x/ day
Poultry (chicken, turkey)						
Meat (beef, pork, lamb)						
Meat alternatives (tofu, tempeh)						
Dairy (cheese, yogurt*) (brand: _____)						
Beans						
Fish/Shellfish						
Eggs						
Nuts/seeds						

**Specify if plain or flavored*

In the past month, how often has the child consumed the following fruits and vegetables?
Select one frequency in each row.

	Rarely/ Never	1-2x/ week	3-4x/ week	5-6x/ week	1x/ day	≥2x/ day
Green, leafy vegetables						
Broccoli/cauliflower						
Potatoes						
Sweet Potatoes						
French fries: Baked ☐ Fried ☐						
Yams						
Peas						
Green Beans						
Carrots						
Berries						
Apples						
Bananas						
Grapes						
Plantains						
Citrus						
Canned fruit packed in: Juice ☐ Water ☐ Syrup ☐						

In the past month, how often has the child consumed the following grains? Select one frequency in each row.

	Rarely/ Never	1-2x/ week	3-4x/ week	5-6x/ week	Daily
Wheat					
Whole wheat bread					
White bread					
Bagels					
Pancakes/Waffles					
Pasta					
Biscuits					
Oats					
Instant Oatmeal					
Infant oat cereal					
Old-fashioned oats					
Cheerios™					
Barley					
Infant cereal					
Pearled barley					
Rice					
White					
Brown					
Yellow					
Rice cakes					
Other: (_____)					
Corn					
Tortillas					
Corn meal					
Grits					
Corn Flakes					

Of the grains that were consumed in the past month, how often were they whole grain products?

a. Never or almost never
b. About ¼ of the time
c. About ½ of the time
d. About ¾ of the time
e. Almost always or always

In the past month, how many cups (8 oz. or 240 mL) did the child consume of the following beverages (not including tube feedings)? Select one frequency in each row.

	Rarely/ Never	1-3 cups/ month	1 cup/ week	2-3 cups/ week	4-6 cups/ week	1 cup/ day	2-3 cups/ day	4-5 cups/ day	≥6 cups/ day
Water									
Oral Rehydration Solution									
Juice (type: _____)									
Milk* (type: _____)									
Soda (type: _____)									
Sports drinks (type: _____)									
Tea** (type: _____)									
Hot cocoa									
Other (type: _____)									

**Skim or fat free, 1%, 2%, whole, lactose-free, chocolate, non-dairy milk equivalents (e.g., almond, soy)*

***Unsweetened, sweetened, etc.*

In the past month, how many cups (8 oz. or 240 mL) did the child consume of the following formulas and/or oral supplements (not including tube feedings)? Select one frequency in each row.

	Rarely/ Never	1-3 cups/ month	1 cup/ week	2-3 cups/ week	4-6 cups/ week	1 cup/ day	2-3 cups/ day	4-5 cups/ day	≥6 cups/ day
Formula (type: _____)									
Human Milk									
Oral supplement(s) (brand: _____) (brand: _____)									