Gaps Nutrition Consultancy

GAPS Nutrition Analysis: Child

DATE: / /

PERSONAL DETAILS

Please legibly print the following nutrition information

Full Name: _____ Preferred: _____

Age: _____ DOB: / / Female ☐ Male ☐ Weight: _____kg Height: _____ cm

Parent Guardian Name:_____ Relationship: _____

Postal Address: _____ State:_____ Postcode:_____

YOUR HOME LAND LINE PHONE NUMBER IS REQUIRED FOR PHONE CONSULTATIONS

Home Phone: _____ Mobile Phone: _____

Referring Practitioner: _____

PRIMARY CONCERNS *(You may add additional information on a separate attached sheet if you like)*

Please indicate the following with a tick

Is the GAPS Program:

☐ New to you or
☐ You have been doing the GAPS Program for _____ (weeks/months)

Please provide your child's 3 main reasons (listed by priority) for coming to the GAPS Program and briefly describe your child's most troubling symptoms and health concerns.

1

2

3

Have you received a clinical diagnosis? Comment: _____

Please list any treatment interventions you have tried previously for this condition and briefly discuss the outcome:

HALTH HISTORY

Please indicate the following with a tick

☐ My child received several antibiotic treatments overtime for reoccurring infections. List infections below:

_____

☐ Was your child breast fed: How long for? _____

☐ Vaccinations (including flu vaccine): Please comment: _____

☐ Was your child developing normally in the first year of life, followed by a number of regressive developmental delays and behavioural problems? Please comment:

HALTH HISTORY continued

GUT AND PSYCHOLOGY SYNDROME CONDITIONS:

Please indicate whether your child has been diagnosed with any of the following or whether you suspect a problem.

☐ Autism Spectrum Disorder	☐ Schizophrenia	☐ Dyspraxia	☐ Anxiety Disorder
☐ Asperger's Syndrome	☐ Bipolar Disorder	☐ Dyslexia	☐ Panic Disorder
☐ Attention Deficit Disorder	☐ Depression	☐ Eating Disorder	☐ Tourrete's Syndrome
☐ Attention Deficit Hyperactivity Disorder	☐ Obsessive Compulsive Disorder	☐ Oppositional Defiance Disorder	☐ Conduct Disorder

☐ Other psychological disorders:_____

GUT AND PHYSIOLOGY SYNDROME CONDITIONS:

Please indicate whether you child relates to any of the following.

☐ Fibromyalgia	☐ Eczema/Dermatitis	☐ Type 1 Diabetes	☐ Crohn's Disease
☐ Lupus	☐ Asthma	☐ GERD (Reflux)	☐ Celiac
☐ Pyrroles Disorder	☐ Psoriasis	☐ Multiple Sclerosis	☐ Ulcerative Colitis
☐ Antibiotic Associated Diarrhoea	☐ Epilepsy	☐ Hashimotos Thyroiditis	☐ IBS

Other Physiological conditions:_____

GAPS RELATED HEALTH & BEHAVIOUR ISSUES:

Please indicate whether your child experiences any of the following.

☐ Gut Dysbiosis	☐ Ear infections	☐ Hay fever	☐ Learning problems
☐ Dark circles under eyes	☐ Chest infections	☐ Poor memory	☐ Mind Fog
☐ Pale skin complexion	☐ throat infections/strep	☐ Lethargy	☐ Low immunity
☐ Muscle & joint pain	☐ Head Sweats	☐ Migraine Headaches	☐ Difficult to focus
☐ Poor sleep patterns	☐ Irritable	☐ Self harms	☐ Aggressive to others
☐ Antibiotic Associated Diarrhoea	☐ Food Allergies Sensitivities	☐ Nasal drip	☐ Anemia/iron deficient

Other symptoms & conditions:_____

STOOLS / URINARY TRACT / STOMACH ACID PRODUCTION

Please respond to the following by circling the appropriate number

0 = Never or NA **1** = Occasionally **2** = Frequently **3** = Most of the time or Always

STOOLS		**URINARY TRACT**	
Alternate between diarrhea and constipation	0 1 2 3	Wets the bed	0 1 2 3
Diarrhoea	0 1 2 3	Constant urination	0 1 2 3
Constipation	0 1 2 3	Thrush (Yeast overgrowth)	0 1 2 3
Experience pain when moving bowels	0 1 2 3	Cystitis	0 1 2 3
Avoids going to the toilet – holds on	0 1 2 3	Menstrual Disorder (women only)	0 1 2 3
Hard round stomach/abdomen	0 1 2 3		
Stools tend to float	0 1 2 3	**STOMACH ACID PRODUCTION**	
Flatulence	0 1 2 3	Pain when eating	0 1 2 3
Undigested food is visible in stools	0 1 2 3	Pain after eating	0 1 2 3
Mucus in stools	0 1 2 3	Heart Burn	0 1 2 3
Stools look green	0 1 2 3	Metallic acid taste in mouth	0 1 2 3
Stools look pasty yellow	0 1 2 3	Bloating after a meal	0 1 2 3
Constant abdomen pain/cramps	0 1 2 3	Colic / Reflux	0 1 2 3
Tummy sore to touch	0 1 2 3	Excess burping after a meal	0 1 2 3

Please indicate how many bowel movements you have per day: _____ & per week: _____

Are you familiar with using enemas? Y N If yes, how often? _____

Do you use antacids? Y N Do you take digestive enzymes ? Y N

Other: _____

MEDICATIONS

Please list any current prescription or over the counter medications *(ie: antacids, anti depressants, anti inflammatory, blood pressure, cholesterol lowering drugs, diuretics, heart meds, hormones, laxatives, oral contraceptives, steroids, psychotic drugs and thyroid medication).*

Medication	Purpose & how long	Dosage

SUPPLEMENTS

Please list any current supplements *(ie fish oils, probiotics, zink, B vitamins, humic acids etc).*

Supplement	Brand	Amount	When	How long

MEDICAL

Please list other medical conditions, complications, hospital stays, operations etc.

TESTS

☐ Organic Acid Test ☐ Comprehensive stool analysis ☐ Hair Analysis

PHYSICIANS

Who is your primary care physician? _____

☐ Speech Pathologist ☐ Occupational Therapist ☐ Psychologist ☐ Dietitian

CHEMICAL EXPOSURE

Does you use fluoride tooth paste?	Y	N	Are you renovating your home?	Y	N
Do you use soaps and other chemical personal care items ?	Y	N	Does your child eat non organic foods?	Y	N
Does your child drink unfiltered water?	Y	N	Is your child regularly exposed to cigarette smoke?	Y	N
Does your child swim in chlorinated swimming pools?	Y	N	Do you use air fresheners?	Y	N
Do you use strong chemical house hold cleaners?	Y	N	Do you wear perfume or burn candles?	Y	N
Do apply sunscreens on your child's skin?	Y	N	Have you bought new furniture recently?	Y	N
Do you use aluminium cookware?	Y	N	Do you use the microwave to heat food?	Y	N
Do you wrap food in plastic wrap?	Y	N	Do you use regular washing powder?	Y	N

LEISURE & RECREATION

Please list preferred Leisure and Recreation activities

NUTRITION & DIET

DIET RESTRICTIONS & FOOD PREFERENCES

Please indicate with a tick in the box, whether your child identifies with or whether you suspect a problem with the following.

☐ Dysphagia (risk of aspiration)

Explain: _____

☐ Anaphylactic Allergic Reactions ☐ Nuts ☐ Dairy ☐ Nuts

Explain: _____

☐ Food Sensitivities

Explain: _____

☐ Eating Disorder: Anorexia/ Bulimia

Explain: _____

☐ Fussy Eater / Self limits own diet ☐ Eats only a handful of foods

Explain: _____

☐ Food Sensory issues & oral motor problems (shape, texture, colour, food must not touch other foods etc)

Explain: _____

☐ Child insists on using specific spoon or cup etc

Explain: _____

☐ Mealtime management issues ☐ Won't sit still

Explain: _____

Please list the foods your child tends to avid (least likes)

Please list your preferred foods and snacks (favourite food)

Your child's rate of eating? ☐ Slow ☐ Moderate ☐ Fast ☐ Do not chew food enough

Does you child look malnourished? Yes ☐ No ☐

COMMUNICATION

Please briefly describe your child's level of communication and ability to comprehend.

Gaps Nutrition Consultancy

CONSENT, DISCLOSURE AND DISCLAIMER OF SERVICES PROVIDED

I request Linda Paterson, GAPS Nutrition Consultant, to provide nutrition support and information on implementing the GAPS Nutrition Protocol for my child (child's name) _____
and develop a comprehensive individualized nutrition intervention plan for the purpose of improving my child's nutrition and digestive health.

I understand that Linda Paterson has a bachelor degree in Health Science from Charles Sturt University, is currently completing studies in nutrition and has extensive experience in working in both the Disability and Mental Health field with the Department of Disabilities, Department of Justice and non government organisations.

I understand that these services solely intend to focus on the GAPS Nutrition Protocol which provides intervention strategies to parents in how to navigate and implement the program and by no means does it intend to replace the advice from a medical practitioner.

I (full name) _____ understand that the support services provided by GAPS Nutrition Consultancy are not intended to diagnose, prescribe or treat disease and is not considered a substitute for regular medical care.

_____ _____

Client Signature **Date**

Gaps Nutrition Consultancy

NUTRITION ANALYSIS

Food Intake Please record everything your child eats & drinks over the next three days as accurately as possible. Try to be specific about the food description. Example: was it home made, baked, fried, grilled organic or frozen commercial foods etc. Please include supplements and medications given. Also record general wellbeing and any other symptoms.

DAY ONE **Name:** **Date:**

BREAKFAST	SUPPLEMENTS/MEDS

MORNING TEA	SUPPLEMENTS/MEDS

LUNCH	SUPPLEMENTS/MEDS

AFTERNOON TEA	SUPPLEMENTS/MEDS

DINNER	SUPPLEMENTS/MEDS

SNACKS	SUPPLEMENTS/MEDS

Is the above an accurate representation of your child's diet? Yes ☐ No ☐ If yes, please describe

BEHAVIOUR / PAIN / OBSERVATIONS

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NUTRITION ANALYSIS

DAY TWO **Name:** **Date:**

BREAKFAST	SUPPLEMENTS/MEDS

MORNING TEA	SUPPLEMENTS/MEDS

LUNCH	SUPPLEMENTS/MEDS

AFTERNOON TEA	SUPPLEMENTS/MEDS

DINNER	SUPPLEMENTS/MEDS

SNACKS	SUPPLEMENTS/MEDS

Is the above an accurate representation of your child's diet? Yes ☐ No ☐ If yes, please describe

BEHAVIOUR / PAIN / OBSERVATIONS

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NUTRITION ANALYSIS

DAY THREE Name: **Date:**

BREAKFAST	SUPPLEMENTS/MEDS

MORNING TEA	SUPPLEMENTS/MEDS

LUNCH	SUPPLEMENTS/MEDS

AFTERNOON TEA	SUPPLEMENTS/MEDS

DINNER	SUPPLEMENTS/MEDS

SNACKS	SUPPLEMENTS/MEDS

Is the above an accurate representation of your child's diet? Yes ☐ No ☐ If yes, please describe

BEHAVIOUR / PAIN / OBSERVATIONS

YOUR QUESTIONS

Please record your main questions here and advise on how a nutrition consultant can best support you with GAPS.

ADDITIONAL INFORMATION

Please return post documentation to your GAPS Practitioner in advance (prior to your appointment):