

WIC Nutrition/Health Assessment Child

Date _____

(Health Goal: Grow and develop in a nurturing home and begin to make dietary and lifestyle habits for a lifetime of good health.)

Child's name _____

Child's date of birth _____

1. Complete this question if this child is less than 2 years of age. If not, go to Question 2.

How much did this child weigh at birth?

_____ Pounds _____ Ounces

What was this child's length at birth? _____ Inches

Was this child born early? Yes No

If yes, how many weeks early? _____

2. Which of these meals/snacks does this child usually eat?

- | | |
|--|--|
| <input type="checkbox"/> Breakfast | <input type="checkbox"/> Morning snack |
| <input type="checkbox"/> Lunch | <input type="checkbox"/> Afternoon snack |
| <input type="checkbox"/> Dinner/supper | <input type="checkbox"/> Evening snack |

3. How would you describe this child's appetite?

- Good Fair Poor

4. Does this child feed her/himself?

- Always Sometimes Never

5. How would you describe mealtimes with this child?

- | | |
|---|---|
| <input type="checkbox"/> Always pleasant | <input type="checkbox"/> Never pleasant |
| <input type="checkbox"/> Usually pleasant | <input type="checkbox"/> Seldom eats with child |
| <input type="checkbox"/> Sometimes pleasant | |

6. How many days does your family eat together each week?

- Never 1-3 days 4-7 days

7. Does your family watch TV during family mealtime?

- Always Sometimes Never

8. Does this child eat or take a meal from a fast-food restaurant 2 or more times per week?

- Yes No

9. Is there a working stove, oven, and refrigerator where this child lives?

- Yes No

10. Were there any days last month when your family didn't have enough food to eat or enough money to buy food?

- Yes No

11. Are you concerned about this child's weight?

- Yes No

12. Is this child a vegetarian?

- Yes No

13. Is this child lactose intolerant?

- Yes No

14. How much juice does this child drink daily?

- | | |
|---|---|
| <input type="checkbox"/> Less than 4 ounces | <input type="checkbox"/> 9-12 ounces |
| <input type="checkbox"/> 4-8 ounces | <input type="checkbox"/> Greater than 12 ounces |

15. Is this child often constipated or have problems with bowel movements?

- Yes No

16. How many glasses of water does this child drink on a typical day?

- | | |
|-------------------------------|------------------------------------|
| <input type="checkbox"/> None | <input type="checkbox"/> 4-7 |
| <input type="checkbox"/> 1-3 | <input type="checkbox"/> 8 or more |

17. Does this child eat or crave non-food items like clay, laundry starch, paint chips, paper, dirt, or ice?

- Yes No

18. Does this child use a bottle?

- Yes No

19. Does this child take a bottle to bed at night or carry a bottle or training cup around during the day?

- Yes No

20. Does this child take a pacifier dipped in honey, syrup, or sugar?

- Yes No

21. When does this child visit a doctor or clinic?

- At regular check-ups
 Just when sick
 Never

22. Does this child receive regular dental care (visit a dentist)?

- Yes No

23. Does this child take a vitamin/mineral/herbal supplement?

- Yes No

24. Is this child currently in foster care?

- Yes No

If yes, has the child changed foster homes in the last 6 months?

- Yes No

25. Does this child eat any of the following:

- | |
|---|
| <input type="checkbox"/> Raw or undercooked meat, fish, poultry, or eggs |
| <input type="checkbox"/> Unpasteurized milk/soft cheeses |
| <input type="checkbox"/> Unheated lunch meats, hot dogs, or other processed meats |
| <input type="checkbox"/> Raw sprouts |
| <input type="checkbox"/> Unpasteurized juice |
| <input type="checkbox"/> Raw or undercooked tofu |
| <input type="checkbox"/> None |

26. Does this child eat any of these foods? (Check all that apply.)

- | | |
|--|---|
| <input type="checkbox"/> Round or hard candy | <input type="checkbox"/> Nuts and seeds |
| <input type="checkbox"/> Pretzels and chips | <input type="checkbox"/> Popcorn |
| <input type="checkbox"/> Raw carrots or celery | <input type="checkbox"/> Whole grapes |
| <input type="checkbox"/> Peanut butter | <input type="checkbox"/> Raisins |
| | <input type="checkbox"/> Hot dogs |
| | <input type="checkbox"/> Marshmallows |

This institution is an equal opportunity provider.

Child's name _____

Child's date of birth _____

27. Which of these foods/beverages does this child normally eat or drink?

28. Does this child currently have any of the following as **diagnosed by a primary care provider:**

Grains

- Bread
- Rolls
- Bagels
- Muffins
- Popcorn
- Noodles/pasta/rice
- Tortillas
- Crackers
- Cereal/grits

Vegetables

- Corn
- Peas
- Potatoes
- French fries
- Greens (collard, spinach)
- Vegetable/tomato juice
- Green salad
- Broccoli/cauliflower
- Green beans
- Carrots
- Tomatoes
- Sweet potatoes
- Green chile/green pepper

Fruits

- Apples
- Oranges
- Grapefruit
- Grapes
- Berries
- 100% Fruit juice
- Bananas
- Pears/plums
- Melon
- Peaches
- Plums

Milk and Other Dairy Products

- Fat-free (skim) milk
- Low-fat (½–1%) milk
- Reduced-fat (2%) milk
- Whole milk
- Flavored milk
- Cheese
- Yogurt
- Cottage cheese
- Ice cream
- Unfortified or imitation milk

Meat and Meat Alternatives

- Beef/hamburger
- Pork
- Chicken
- Turkey
- Fish
- Cold cuts (hot dogs, lunch meat)
- Sausage
- Peanut butter/nuts
- Eggs
- Dried beans/peas
- Tofu

Fats and Sweets

- Margarine/butter
- Lard/shortening
- Gravy
- Bacon
- Chips
- Doughnuts/pastries
- Pie
- Cake/cupcakes
- Jell-o

Other Beverages

- Regular soft drinks
- Diet soft drinks
- Fruit-flavored drinks
- Coffee/tea
- Sweet tea
- Beer/wine/liquor
- Energy drinks
- Sports drink (like Gatorade)

Problem	Y	N
Failure to thrive		
Dental problems		
Fetal alcohol syndrome		
Cancer		
Celiac Disease		
Central nervous system disorders like epilepsy, cerebral palsy or spina bifida		
Depression		
Developmental, sensory or motor delays interfering with the ability to eat		
Diabetes		
Food allergies List:		
Gastro-Intestinal disorders like ulcers, liver disease, pancreatic problems, or gallbladder disease		
Genetic and congenital disorders like cleft lip, cleft palate, thalassemia major, Down's syndrome, or sickle cell disease		
Hypertension (high blood pressure)		
Hypoglycemia (low blood sugar)		
Inborn errors of metabolism like PKU or galactosemia		
Infectious disease like hepatitis, HIV, TB, or AIDS		
Other medical conditions like lupus, heart disease, cystic fibrosis, or asthma with daily medication		
Recent major surgery, accident, or burns		
Renal (kidney) disease		
Thyroid disorders		
Other diagnosed conditions List:		

Signature of person completing this form _____

Date _____

Relationship to child _____

DO NOT WRITE BELOW THIS LINE

CPA Signature/Title _____

Date _____