

WIC Nutrition/Health Assessment – Postpartum Woman

Name _____ Date of Birth _____ Date _____

Please complete the following questions to help WIC staff better understand your needs.

1. Which foods/beverages below do you usually eat or drink?

<p>Breads & Grains:</p> <p><input type="checkbox"/> Bread <input type="checkbox"/> Noodles <input type="checkbox"/> Rice</p> <p><input type="checkbox"/> Rolls <input type="checkbox"/> Pasta <input type="checkbox"/> Crackers</p> <p><input type="checkbox"/> Tortillas <input type="checkbox"/> Cereal</p> <p>I also eat: _____</p> <p>Meats & Protein:</p> <p><input type="checkbox"/> Hamburger <input type="checkbox"/> Lunch meat <input type="checkbox"/> Sausage</p> <p><input type="checkbox"/> Chicken <input type="checkbox"/> Tofu <input type="checkbox"/> Peanut butter</p> <p><input type="checkbox"/> Fish <input type="checkbox"/> Beans <input type="checkbox"/> Pork</p> <p>I also eat: _____</p> <p>Other Beverages:</p> <p><input type="checkbox"/> Soft drinks <input type="checkbox"/> Sweet tea <input type="checkbox"/> Unsweet tea</p> <p><input type="checkbox"/> Juice <input type="checkbox"/> Coffee <input type="checkbox"/> Energy drinks</p> <p>I also drink: _____</p>	<p>Vegetables & Fruits:</p> <p><input type="checkbox"/> Broccoli <input type="checkbox"/> Potatoes <input type="checkbox"/> Bananas</p> <p><input type="checkbox"/> Green beans <input type="checkbox"/> Corn/Peas <input type="checkbox"/> Oranges</p> <p><input type="checkbox"/> Tomatoes <input type="checkbox"/> Apples <input type="checkbox"/> Berries</p> <p>I also eat: _____</p> <p>Milk & Dairy:</p> <p><input type="checkbox"/> Cow's milk <input type="checkbox"/> Lactose free milk <input type="checkbox"/> Yogurt</p> <p><input type="checkbox"/> Soy milk <input type="checkbox"/> Cottage cheese <input type="checkbox"/> Cheese</p> <p>I also eat & drink: _____</p> <p>Other Foods:</p> <p><input type="checkbox"/> Doughnuts <input type="checkbox"/> Butter/Margarine <input type="checkbox"/> Gravy</p> <p><input type="checkbox"/> Cake <input type="checkbox"/> Cookies <input type="checkbox"/> Chips</p> <p>I also eat: _____</p>
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| <p>2. Are you currently breastfeeding? <input type="checkbox"/> Yes <input type="checkbox"/> No
How is breast feeding going? _____</p> <p>3. Are you on a special diet or diet to lose weight?
<input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>4. Have you used starvation, diet pills, laxatives, or vomiting as a method to lose weight in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>5. Have you ever had bariatric surgery?
<input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>6. Are you often constipated or have problems with bowel movements? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>7. How many glasses of water do you drink daily?
_____ glasses</p> <p>8. How often are you physically active? ___X per wk</p> <p>9. Do you take daily vitamins or minerals?
<input type="checkbox"/> Yes <input type="checkbox"/> No
Does the supplement have iodine?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
Do you take herbal or botanical supplements?
<input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>19. What health issues do you have?
_____</p> <p>20. If you could wish for one healthy habit for yourself in the next six months, what would it be?
_____</p> | <p>10. Do you eat/crave non-food items like clay, paint chips, dirt, or ice? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>11. Do you feel you have enough food to feed your family? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>12. Did your last baby weigh 5 pounds 8 ounces or less at birth? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>13. Did your last baby weigh 9 pounds or more at birth? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>14. Did your last baby have a congenital birth defect like neural tube defect, cleft palate, or cleft lip?
<input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>15. Was your last baby born early?
<input type="checkbox"/> Yes, _____ wks <input type="checkbox"/> No</p> <p>16. Did you have gestational diabetes or preeclampsia with any pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>17. In your most recent pregnancy, did you have a miscarriage, or death of a fetus ≥ 20 weeks (stillborn), or delivered a baby who died within 28 days of birth? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>18. Have you discussed family planning options (birth control) with your doctor?
<input type="checkbox"/> Yes <input type="checkbox"/> No</p> |
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----- THIS SIDE IS FOR WIC STAFF TO COMPLETE -----

Below are suggested questions to facilitate WIC discussion.

- How are you feeling today? *(Assess for 'baby blues'/depression, postpartum support, appetite, skipping meals [concern about adequate calories & nutrients])*
- What are your mealtimes like? *(Assess environment [TV, phones, tablets at table], family meals, timing of meals, pattern [3 meals/2-3 snack], intake changes, intolerances, any special dietary needs, food preparation [who prepares, fast food/wk])*
- What would you like to change about your eating? Activity level?
- Is there anything you would like to eat more or less of?
- If breastfeeding, how is breastfeeding going? *(Assess support system, nipple pain, latch, milk expression/pumping)*
- Do you ever have a hard time chewing or eating certain foods? *(tooth loss, impaired ability to eat, oral health)*
- What has been helpful at this visit?

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